UMATILLA-MORROW HEAD START - SEIZURE PROTOCOL
(To Be Completed by Child's Parent and Physician)

Child's Name:_____ Date of Birth:_____

Provider Name:_____ Telephone:_____

Is child's seizure condition diagnosed by a physician? Yes No If "Yes", when was it diagnosed and what was the diagnosis?_____

What does your child's seizures typically look like?_____

How often does your child have a seizure?_____

When is your child likely to have a seizure?_____

Are seizures typically associated with fever? Yes No

Has child ever been hospitalized for seizures? Yes No

Is medication administration by Head Start staff required while child is in our immediate care? Yes No

If "Yes", explain why medication(s) cannot be administered at home:_____

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use - When to Use

Symptoms of Seizure:_____

_____

_____

Head Start staff should do the following if child shows symptoms of seizure activity at school:

maintain a calm presence and offer continuous verbal reassurance,

protect child from injury from objects in her surroundings, remove any furniture or objects that may injure, (DO NOT RESTRAIN CHILD OR PUT ANYTHING INTO CHILD'S MOUTH)

prevent injury by placing a pillow or soft object under child's head,

if seizure is severe help child maintain a clear airway by laying child on his/her side,

after seizure reassure and refocus child to surroundings,

Head start should notify parent when: _____

Head Start staff should call 911 Emergency number and seek EMERGENCY MEDICAL CARE if:

seizure lasts longer than 5 minutes

child has one seizure after another without gaining consciousness

child does not resume breathing after seizure has stopped (begin rescue breathing)

other:_____

I request and authorize this **EMERGENCY PROTOCOL** to be followed for the period commencing with the_____day of_____, 20___, through the_____day of_____, 20___, as there exists a valid health reason which makes enacting such protocol necessary. In all cases emergency protocol for seizure shall be reviewed by Head Start staff annually.

Physician Signature:_____ **Date:**_____

My signature below signifies consent for UMCHS staff to enact the **EMERGENCY PROTOCOL** procedures identified by my child's physician in accordance with the time frames listed here. Not to exceed one year.

Parent Signature:_____ **Date**_____

Child/Family Advocates are responsible for ensuring substitute staff are informed of procedures outlined within this seizure protocol. Maintain completed original in Center File with copies to Emergency Contact