HEAD START/EARLY HEAD START
Tri-County Community Council, Inc.
2499 Cypress St. Westville, Fl 32464
(850) 548-9900 FAX (850) 548-5644

SEIZURE HEALTH CARE Form

Child's Name: ______________________________ **D.O.B.:** ___/___/___

Parent/Guardian Name: ______________________________ **Phone:** ______________

Parent/Guardian Name: ______________________________ **Phone:** ______________

Emergency contact: ______________________________ **Phone:** ______________

Allergies: ____

Insurance: ____

Health Care Provider: ______________________________ **Phone:** ______________

Teacher/Family Advocate: ______________________________ **Site/Loc. ID:** ______________

Seizure Disorder:

Type: ______________________________ **Date of diagnosis:** ___/___/___

Description: **(What should staff be alerted to?)** ______________________________

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Response: **(How would you like staff to respond?)** ______________________________

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Current Medications:			
Medication(s) Name	**Dosage Amount**	**Prescribed times to give**	**Dosage Frequency (How far apart to be given)**
1.			
2.			
3.			

Will medication be at school? □ **Yes** □ **No**
If yes, Medication Authorization Form, required prior to medication administration. Received: □ **Yes** □ **No**
SEIZURE CARE Form

rk7/11/11