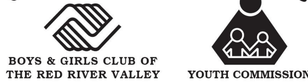

Youth Commission
Individual Child Care Plan (ICCP)
Seizure

Child's Name:___________________________ DOB:____________________

School Site:________________________________

Diagnosed Medical Condition:____

1. Is this a current health issue? YES NO
   a. If yes, describe how often it occurs:___________________________________
   ____

   b. What symptoms and behaviors does your child experience?
      1) Before the seizure:____
      ____
      2) During the seizure:____
      ____
      3) After the seizure:____
      ____

   c. List any restrictions at the Youth Commission:_________________________
   ____

2. What medication and treatment plan is your child following? (Complete MEDICATION PERMISSION FORM if necessary)

____
____
____

3. If your child does not respond to medication and treatment what would you like the staff to do?

____
____
____

YOUTH COMMISSION / BOYS & GIRLS CLUB OF THE RED RIVER VALLEY

Fargo Youth Center
2500 18th Street South
Fargo, ND 58103
P: 701/235-2147
F: 701/235-9970

Youth Center @ Rose Creek
4809 University Drive South
Fargo, ND 58103
P: 701/478-4066
F: 701/478-4067

Moorhead Youth Center
215 10th Street North
Moorhead, MN 56560
P: 218/284-1199
F: 218/284-1201

www.bgcrrv.org

Youth Commission
Individual Child Care Plan (ICCP)
Seizure

4. Can your child administer the medication and treatment themselves or does your child need help? On Own Needs Assistance

 a. If needs assistance, what does the staff need to do?______________________
 ____

5. Where is the medication stored?____

6. Is there any additional information staff must know in order to best serve your child?
____
____
____

Parent Signature:____________________________________ Date:_____________