

Family and Physician Management Plan Summary for Children and Adolescents with a Seizure Disorder

This form will help you and your physician review current services and service needs. Please answer the questions about your current services on this page. Your physician will review your responses and complete the rest of the form.

Child's name _____ Today's date _____

Person completing the form _____

CURRENT SERVICES

1. Please list your/your child's current medications and any side effects.

2. When was your/your child's last seizure?
How many seizures do you/does your child have per week or per month?

3. What is your/your child's current school program?
School name _____ Grade _____
Teacher _____ Telephone _____

4. Do you/does your child receive any support services and other special programs at school (e.g., physical therapy, access to resource room)? Please list.

5. Who are your/your child's other medical and dental service providers?
Dentist _____
Neurologist _____
Other _____

6. Who are your/your child's other community service providers?
Community health nurse _____
Other _____

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The Management Plan Summary should be completed at each annual review and more often as needed. It is intended to be used with the Guidelines for Care, which provide a more complete listing of clinical issues at different ages as well as recommended evaluations and treatments.

Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Family's Questions					
Growth and Nutrition					
Dental Care					
Other Medical Problems Hearing loss or vision concerns Neuromotor problems Constipation, enuresis Sleep disorder Note any side effects of medications.					

Family and Physician Management Plan Summary for Children and Adolescents with a Seizure Disorder (continued)

Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
<p>Associated Developmental/Learning Issues</p> <p>Describe current school achievement</p> <p>Review early intervention (EI) or other school services (individualized family service plan [IFSP] or individualized education program [IEP])</p> <p>Learning disability</p> <p>Speech-language disorder</p> <p>Developmental delay or mental retardation</p>					
<p>Associated Behavior/Mental Health Problems</p> <p>Inattention or hyperactivity</p> <p>Aggression</p> <p>Oppositional behavior</p> <p>Anxiety, depression</p> <p>Schizophrenia (psychotic disorder)</p> <p>High-risk behaviors</p>					
<p>Social Skills</p> <p>Involvement in peer-group activities at school and in the community (determine which supports are needed)</p>					

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Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Self-Care and Independence					
Family Support Services					
Anticipatory Guidance List issues discussed and materials provided					
Collaboration with Community Agencies Communication with school					
Comments					

Next update of the Management Plan Summary _____

Signature _____ Date _____
(Child and parent)

Signature _____ Date _____
(Health professional)