**Individual Health Care Plan**

**Epilepsy**

This plan relates to the health care needs provided to this school to the child / young person named below in relation to the safe management of the condition above. School staff involved in the day to day care of this child should be made familiar with the contents of this plan so they are aware of when they need to act, and what they and others need to do.

**Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Class\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Having epilepsy means that you have a tendency to have epileptic seizures. A seizure happens when there is a sudden burst of intense electrical activity in the brain, which causes a temporary disruption in the way the brain normally works.*

 *Epilepsy.org.uk*

**Emergency Contact details:**

**Contact 1**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact numbers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact 2**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact numbers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency care**

Please fill in this section if your child has been prescribed emergency medication for their epilepsy.

**Child’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Class** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and strength of medication**

|  |
| --- |
|  |

**When should the medication be given?**

|  |
| --- |
|  |

**How much medication should initially be given?**

|  |
| --- |
|  |

**What action should be taken if medication is given?**

|  |
| --- |
|  |

**Condition/cause of epilepsy, anything that makes seizures more likely, early warning signs?**

|  |
| --- |
|  |

**Any other health conditions:**

|  |
| --- |
|  |

**Description of Seizures:**

|  |
| --- |
|  |

**How long do seizures usually last?**

|  |
| --- |
|  |

**What happens after a seizure and how long does it usually take to recover?**

|  |
| --- |
|  |

**Medications given at home** (please include all medications given)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medicine** | **Is this prescribed for epilepsy?** | **Strength/Amount given** | **Times given** |
|  |  |  |  |

**Medication to given in school**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medicine** | **Is this prescribed for epilepsy?** | **Strength/Amount given** | **Times to be given** |
|  |  |  |  |

**Date Plan Completed**

**Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_**

**Heath care plan agreed by**:

Parent/carer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member of school staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parents/carers are responsible for ensuring that the school is aware of their child’s needs and should update the school as necessary.**

**This care plan will be reviewed yearly or more often if required, it will be shared with staff in school that are involved in the child’s care. Copies will be kept in the school office and in the classroom. Parent/carer to have a copy.**

**Plan reviewed**

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_