Individual healthcare plan

Date of plan: ……..

Name: …… Date of birth: ……

Address: ……..

…… Postcode: ……..

Name of parent/carer: …… Telephone: .....

Diagnosis (Including any other conditions): ……

……..

Epilepsy syndrome (if known): ……

Description of child's seizures -

Please give brief a description of each seizure type including possible triggers and any warning signs that a seizure may be about to occur.

Type A: ……..

……..

…….. Typical Duration: ……

☐ This seizure has emergency protocol, see attached.

Type B: ……..

……..

…….. Typical Duration: ……

☐ This seizure has emergency protocol, see attached.

Type C: ……..

……..

…….. Typical Duration: ……

☐ This seizure has emergency protocol, see attached.

Basic seizure management for convulsive seizures

1. Note the time that the seizure starts and ends
2. Move any hazards out of the way
3. Loosen tight clothing and protect the head

Let the seizure run its course. When the convulsions have stopped, place the person in the recovery position and stay with them until they are fully alert. If the seizure shows no signs of stopping after 5 mins (or 2 mins longer than is usual for that person) or the person is injured, call 999.

Please call …….. to inform following a seizure.

* After a seizure, please record the details of the event, including time, date, length and any action taken.

Current Medication

List regular medication with dosages:

1. ……..

2. ……..

3. ……..

4. ……..

If the child has an RCPCH epilepsy passport then please check for up to date information surrounding medication.

Impact on learning/behaviour/classroom performance:

(Young Epilepsy's Assessment of Behaviour and Learning in Epilepsy screening tool can be used to help identify areas at risk)

Communication (understanding/speaking skills): ……

……..

Cognition (including memory & processing speed): ……

……..

Emotional/Behaviour (attention/mood, anxiety, social skills, aggression): ……..

……..

Motor Skills (fine & gross motor skills, coordination): ……

……..

Adjustments needed to the classroom environment:

Any additional provision requirements (inc additional time for exams):

Activities that require special consideration and risk assessment:

Agreement

Who needs to know about the child's condition and have they been informed:

Teacher ☐ SENCO ☐ TA/LSA ☐

Senior Management Team ☐ Office Staff/First Aiders ☐ Lunchtime Supervisors ☐

This plan has been agreed and consent is given for emergency treatment by:

Child/young person/parents/guardians/epilepsy nurse specialist/prescribing doctor.

Name: ……..
(epilepsy nurse specialist or prescribing doctor)

Signature: …….. Date: …….

Name: …… (child/young person)

Signature: …….. Date: …….

Name: …… (parent/guardian)

Signature: …….. Date: …….

Name: ……..

Signature: …….. Date: …….

Position in relation to child: ……..

Date this health care plan should be reviewed: ……

Additional information/instructions: ……

……..

……..

……..

……..

……..

Emergency Protocol - Seizure type …….

Name: …….. D.O.B: …… Year Group/Class: ……..

Emergency medication should be given if seizure type …….. has not stopped after …… minutes,

or if ……..

……..

……..

The emergency medication to be given is: ..……

The strength of the medication to be given is: ……..

It should be given ☐ orally ☐ rectally ☐ into the buccal cavity (between the cheek and gums)

Circumstances when emergency medication should NOT be given: ……..

……..

Circumstances when a SECOND dose of emergency medication may be given: …….

……..

The second emergency medication to be given is: …….

The strength of the medication is: ……..

It should be given ☐ orally ☐ rectally ☐ into the buccal cavity (between the cheek and gums)

AN AMBULANCE SHOULD BE CALLED IF: ……

……..

……..

Please call …… on: …… to inform.

Named trained individuals who may give emergency medication:

1: ……..

2: ……..

3: ……..

4: ……..