KITE RIDGE SCHOOL
CHANGING MINDS

| Student Photo |
|---|

# Individual Epilepsy Care Plan

## Students Details

| | |
|---|---|
| Student's Name | |
| Date of Birth | |
| Address | |
| Telephone number | |

## Family Contact Information

| | |
|---|---|
| Next of Kin Name | |
| Relationship to the student | |
| 1st Contact number | |
| 2nd Contact number | |
| | |
| Additional Emergency Contact Name | |
| Relationship to the student | |
| 1st Contact number | |
| 2nd Contact number | |

## Professionals Details

| | |
|---|---|
| **GP –** Name and surgery | |
| **GP –** telephone number | |
| | |
| **Epilepsy Specialist**<br>Name of Professional and department | |
| **Date of Diagnosis and by whom.** | |

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## INFORMATION ON SEIZURES

| |
|---|
| **Seizure - Type:** |
| **The frequency of seizure on average.** Eg. Daily, weekly, monthly, no pattern. |
| **A description of a typical type of seizure:** eg, what the seizure looks like. |
| **Triggers:** eg – lights, smells, illness |
| **Length/average duration of seizure:** |
| **How to deal with the seizure.** Eg; specifically to help your child. |
| **A description of what constitutes an emergency for the child and the action to take if this occurs**. Eg- when should an ambulance be called? |
| **Are Emergency medications prescribed.** (A permission form also needs to be completed.)<br>**Yes / No** |
| **Activities that should be avoided;** |

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| **Activities that require special precaution** |
|---|
| |
| **Follow up care your child needs (e.g. a rest following a seizure)** |
| |

| **NAME OF MEDICATIION** | **Dose** | **After how many minutes should it be given?** | **How is it administered**<br><br>Orally, Nasally. | **Can a second dose be given?** | **After how many minutes can the second dose be given** |
|---|---|---|---|---|---|
| | | | | Yes / No | |
| | | | | Yes / No | |

*Arrangements for school visits/trips etc*

Risk assessments are completed by school which include checking Health care plans and Epilepsy Health care plan.
Parental responsibility to send in medication if needed.

*Who is responsible in an emergency (state if different for off-site activities)*

Named First Aiders and those trained in administration of Medications.
Two members of staff to administer any medications.

*Plan developed with*

School and Parent/Guardians

*Staff training needed/undertaken – who, what, when*

Staff trained in specific conditions and records are kept at school.

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The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school's policy.

It is my responsibility to ensure that School is informed should anything change.

Additional Forms must be completed before medications can be administered at school.

Signed by: ……..

Name of Parent: ……

Date: ……..

**Checked by**

**Learning Mentor:**

Print Name ……Signed ……..

Date: ……..

**Head teacher**:

Print Name……Signed……

Date…….

**Review Date – July 2019 unless any medical need change.**