Individual healthcare plan

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

Who is responsible for providing support in school	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

Describe what constitutes an emergency, and the action to take if this occurs

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

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

Individual healthcare plan (IHP) for epilepsy

Date: _____ Review date: _____

Child's details

Name	
Group/class/form	
Date of birth	
Address	

Family contact information

1. Contact name	
Relationship to child	
Phone number (work)	
(mobile)	
(home)	
2. Contact name	
Relationship to child	
Phone number (work)	
(mobile)	
(home)	

Clinic/hospital contact

Name	
Role	
Phone number	

GP

Name	
Phone number	

Who is responsible for providing support at school?	

New Anstey House, Gate Way Drive, Yeadon, Leeds LS19 7XY United Kingdom
tel. 0113 210 8800 • email epilepsy@epilepsy.org.uk • epilepsy.org.uk • Epilepsy Action Helpline freephone 0808 800 5050
Registered charity in England (No. 234343)

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Details of epilepsy / epilepsy syndrome

Seizure(s) – type, what happens before, during and after, frequency, and duration

1. _____

_____

2. _____

_____

3. _____

_____

Action to be taken during and after a seizure

1. _____

_____

2. _____

_____

3. _____

_____

Emergency procedure if seizure lasts more than _____ minutes

Is an emergency medicines care plan in place: yes / no

Emergency medicine(s) *(only to be administered by named and trained members of staff):*

Name and dose of medicine	
Named individual(s) who may give medicine	

Epilepsy medicine(s)

New Anstey House, Gate Way Drive, Yeadon, Leeds LS19 7XY United Kingdom
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Registered charity in England (No. 234343)

Name:	Dose:	Time given
Name:	Dose:	Time given
Name:	Dose:	Time given

Support needed after a seizure

Side-effects of medicine(s)

Information about other treatments

Seizure triggers (if known)

Specific support or equipment required (for medical, learning, social, emotional needs)

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Activities that require special precautions, and how to manage

Arrangement for school trips

Other information

This plan has been agreed by (pupil/parent/carer/doctor/school nurse/epilepsy specialist nurse):

Name:	Signature:
Role:	Contact number:

Name:	Signature:
Role:	Contact number:

Name:	Signature:
Role:	Contact number:

Name:	Signature:
Role:	Contact number:

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Name:	Signature:
Role:	Contact number:

Details of staff training required/undertaken

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Date	Time	Length of seizure	Notes

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