

Individual healthcare plan

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, contraindications, 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

| I. 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 | |

| roviding support at school? |
|-----------------------------|
| |

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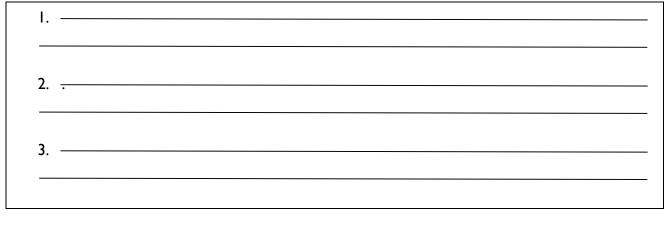


Details of epilepsy / epilepsy syndrome

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

| ١. | |
|----|--|
| 2. | |
| 3. | |
| | |

Action to be taken during and after a seizure



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)





| 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)





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





| Date | Time | Length of seizure | Notes |
|------|------|-------------------|-------|
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