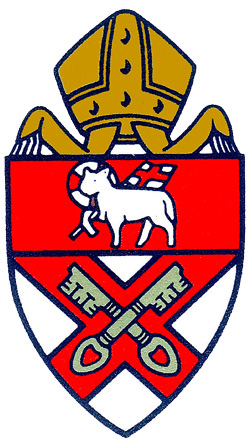
**Epilepsy Healthcare Plan**

Name:……………………………………………………………....... Date of birth:……………….........................................

School:………………………………………………………………… Headteacher:………………………………………………………

Parental contact number:…………………………………………………………………………………………………….

Type of seizure/s experienced:………………………………………………………………………………………………………………………

Symptoms:………………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………

Possible triggers:…………………………………………………………………………………………………………………………………………

Usual procedure following seizure:………………………………………………………………………………………………………………..

Prescribed anti-epileptic medication:……………………………………………………………………………………………………………..

Where medication is stored:…………………………………………………………………………………………………………………………

Member of staff responsible for replenishment of medication:………………………………………………………………………….

Staff trained to give medication: 1)……………………………………………………………………………………………………

2)……………………………………………………………………………………………………

3)…………………………………………………………………………………………………..

Member of staff responsible for Home/School liaison:…………………………………………………………………………………….

|  |
| --- |
| 1. Emergency procedure if seizure lasts for more than…………………………..minutes. 2. Quietly clear the classroom/area of students if you think this is necessary. 3. Trained member of staff (see above) to give rectal diazepam/buccal midazolam with witness of same sex present (if possible). 4. If needed, telephone 999, ask for Ambulance Service, give name of student, address and phone number of school. 5. Telephone parents. 6. Inform Headteacher. 7. Stay with……………………………………………………………………………until ambulance arrives. 8. If parents have not arrived by this time a member of staff will accompany……………………………………………….   to the hospital in the ambulance.   1. Fill in seizure record form for the student file and send copy to parents/GP. |

Name:…………………………………………………………………………………..Date of Birth:………………………………………………..

School:………………………………………………………………………………….Headteacher:………………………………………………..

Parental contact number:………………………………………………………………………………………………………………………………………

**Useful addresses and telephone numbers of professionals involved with**

|  |  |  |
| --- | --- | --- |
| **Service** | **Name** | **Address & Telephone Number** |
| Emergency contact  Epilepsy consultant/specialist  Family GP  Epilepsy/paediatric/  community support nurse  Other |  |  |

**Parental Consent Form**

I give consent for ………………………………………………………..to be given rectal diazepam or buccal midazolam by trained staff in the circumstances described in this document.

I will undertake to inform the school of any changes in the nature of his/her seizures or mediation.

Signed:………………………………………………………………………………………. Date:………………………………………………….

Please print name:……………………………………………………………………………………………………………………………………