



HEALTH CARE PLAN FOR A CHILD/YOUNG PERSON WITH EPILEPSY

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|----------------------------------|---------------------|-------------------------|
| Student Full Name: | | Photo |
| Date of Birth: | Tutor Group: | |
| Date Care Plan Completed: | | |
| Family Contact 1 | | Family Contact 2 |
| Name: | | Name: |
| Phone No: (Home) | | Phone No: (Home) |
| (Work): | | (Work): |
| (Mobile): | | (Mobile): |
| Relationship: | | Relationship: |
| GP Name: | | Consultant Name: |
| GP Address: | | Hospital/Clinic: |
| Telephone Number: | | Telephone Number: |

Please complete the form below with as much detail as possible.

| Type of Seizure |
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| <p>PARTIAL SEIZURES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Remains conscious <input type="checkbox"/> With motor symptoms jerking and stiffening <input type="checkbox"/> With Touch, smell, hearing, taste, and sight symptoms <input type="checkbox"/> With autonomic symptoms heart rate change, internal sensations <input type="checkbox"/> With psychic symptoms in a dream like state <input type="checkbox"/> Complex partial seizures Conscious but impaired movements of the mouth and face (e.g., lip smacking, chewing, and swallowing movements), the hands and arms (e.g., fumbling, picking, and tapping movements), vocalizations (e.g., grunts or repetition of words or phrases). |
| <p>ABSENCE SEIZURES (Formerly called petit mal)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Typical brief - episodes of staring, blinking, unaware of surroundings; usually lasts less than 10 seconds but may last up to 20 seconds <input type="checkbox"/> Atypical - staring spells lasting between 5 to 30 seconds, eye blinking or slight jerking movement of the lips may occur; partial reduction in responsiveness. <input type="checkbox"/> Myoclonic - brief jerks of a muscle or group of muscles; usually involving the neck, shoulders, and upper arms. <input type="checkbox"/> Atonic Sudden loss of muscle strength, eyelids may droop, head may nod, objects may be dropped, or the child may fall to the ground; usually lasts less than 15 seconds, injury is common. <input type="checkbox"/> Clonic Rhythmic- jerking movements of the arms and legs, maybe generalised. <input type="checkbox"/> Tonic- sudden stiffening movements of the body, arms, or legs involving both sides of the body; usually last less than 20 seconds. <input type="checkbox"/> Tonic-Clonic (Formerly called grand mal) <input type="checkbox"/> Convulsive seizures, body briefly stiffens followed by a jerking motion of the arms and legs; loss of consciousness and falls frequently occur, excessive saliva production may be present, possible loss of bowel and bladder control; usually lasts a couple of minutes, the child is often tired or confused after the seizure and may want to go to sleep. |

If your son/daughter experiences any other symptoms before, during or after a seizure, please provide more information below:



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| Known triggers – if any: | |
| Date of last seizure: | |
| Usual duration of seizure: | |
| Recovery time: | |
| Actions – Please advise us on how you care for your son/daughter both during and after a seizure: | |

Current medication summary:

| Anti-Epileptic Medication Taken | Method Oral, Rectal, Gel (If rectal Diazepam or Buccal Midazolam are being used then you will be sent a separate form to fill in for this) | Dose (mg or ml) | Frequency (times daily) | Side effects of this medication |
|---------------------------------|--|--------------------|----------------------------|---------------------------------|
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Special Considerations: *(discuss further with Student Services/Health & Safety)*

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| Swimming | |
| Physical Education | |
| Practical Lessons | |
| School Trips | |
| Any other information you feel may be important for the school to be aware of: | |

Note for parents:

Parents/carers are reminded of the importance of informing schools/respite carers of any changes in treatment/medication or ongoing concerns/changes in episode patterns.

CONFIDENTIALITY: For reasons of safety and rapid access, this form may be displayed on a notice board in the staff room and in subject department offices.

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| Signed: <i>(parent/carer)</i> | Print Name: | Date: |
|--------------------------------------|--------------------|--------------|

Office Use Only

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|-----------------------------|------------------------------------|
| Health Care Plan Agreed by: | Copy sent to parent date: |
| Date Care Plan Created: | Added to Medical Register on date: |