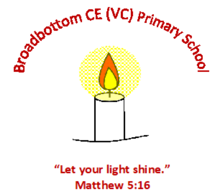
Broadbottom CE (VC) Primary School



EPILEPSY FORM

CHILD'S NAME………

CLASS………………………………… DATE OF BIRTH:…………………………… AGE:…………………………………

ADDRESS:………

………

PARENT CONTACT NUMBER:……………………………………………………………………………………………

GP'S NAME:……

GP'S TELEPHONE NUMBER……………………………………………………………………………………………………

CONSULTANT(S) ………

HOSPITAL TELEPHONE NUMBER:…………………………………………………………………………………………

TYPE OF SEIZURE:………

EXPECTED PRESENTATION:……………………………………………………………………………………………………

HOW LONG DO THEY USUALLY LAST? ……………………………………………………………………………

………

DO YOU HAVE A CARE PLAN YES / NO

IF YES PLEASE GIVE A COPY TO THE SCHOOL OFFICE

ARE THERE ANY TRIGGERS/AURAS KNOWN? IF YES, CAN AVOIDING STEPS BE TAKEN?

PLEASE NOTE THEM ………

………

EXPECTED FREQUENCY OF SEIZURE(S) ……………………………………………………………………………

WHAT ACTION TO TAKE DURING SEIZURE ………………………………………………………………………

………

WHAT AFTER-EFFECTS AND RECOVERY TIME MAY BE EXPECTED? ………………………………………

………

………

………

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ACTION TO BE TAKEN FOLLOWING ATTACK……………………………………………………………………………………

……

……

DETAIL OF MEDICATION REQUIRED:………………………………………………………………………………………

……

DETAILS OF ANY EXPECTED SIDE EFFECTS OF MEDICATION:………………………………………………………

……

DETAILS OF ANY LIMITATIONS IMPOSED BY THIS CONDITION WHILST CHILD IS IN SCHOOL

……

……

COMMENTS:……

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SIGNED…………………………………………………………..**(Parent/Carer)**

DATE…………………………………………….