



**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** .....

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**EXPECTED FREQUENCY OF SEIZURE(S)** .....

**WHAT ACTION TO TAKE DURING SEIZURE** .....

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**WHAT AFTER-EFFECTS AND RECOVERY TIME MAY BE EXPECTED?** .....

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**ACTION TO BE TAKEN FOLLOWING ATTACK**.....

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**DETAIL OF MEDICATION REQUIRED:**.....

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**DETAILS OF ANY EXPECTED SIDE EFFECTS OF MEDICATION:**.....

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

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**COMMENTS:**.....

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

**DATE**.....