



**EPILEPSY  
ACTION**

# Individual healthcare plan (IHP) for epilepsy

[epilepsy.org.uk](https://epilepsy.org.uk)

**Date:** \_\_\_\_\_ **Review date:** \_\_\_\_\_

### Child's details

Name	
Group/class/form	
Date of birth	
Address	

### Family contact information

1. 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	

Who is responsible for providing support at school?	
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### Details of epilepsy / epilepsy syndrome

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

**1:**

**2:**

**3:**

**Action to be taken during and after a seizure**

**1:**

**2:**

**3:**

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	

Emergency 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:	
Role:	
Signature:	
Contact number:	

Name:	
Role:	
Signature:	
Contact number:	

Name:	
Role:	
Signature:	
Contact number:	

Name:	
Role:	
Signature:	
Contact number:	

Name:	
Role:	
Signature:	
Contact number:	

**Details of staff training required/undertaken**

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Date	Time	Length of seizure	Notes



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