1



Individual healthcare plan (IHP) for epilepsy

**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? |  |

Details of epilepsy / epilepsy syndrome

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: |  |

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| Name: |  |
| Role: |  |
| Signature: |  |
| Contact number: |  |

|  |  |
| --- | --- |
| Name: |  |
| Role: |  |
| Signature: |  |
| Contact number: |  |

Details of staff training required/undertaken

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Notes** |  |  |  |  |  |  |  |
| **Length of seizure** |  |  |  |  |  |  |  |
| **Time** |  |  |  |  |  |  |  |
| **Date** |  |  |  |  |  |  |  |



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**Epilepsy Action Helpline freephone 0808 800 5050**

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