MHS EPILEPSY MEDICAL FORM

Please complete this form and return to the school.
You will also need to complete the One Page Medical Summary

STUDENT INFORMATION AND CONTACT DETAILS

Name _____

Date of Birth _____

Name of Family Doctor _____

Telephone Number _____

Parent/Guardian 1 _____

Contact numbers _____

Parent/Guardian 2 _____

Contact numbers _____

Other designated contacts _____

Contact numbers for other designated contacts _____

Siblings in school/college _____

_____

MEDICAL CONTACTS

Family Doctor _____

Hospital attended _____

Consultant _____

Epilepsy Nurse _____

Other specialist (s) _____

_____

MEDICAL INFORMATION

What type of epilepsy has the student been diagnosed with? _____

_____

_____

What type (s) of seizures could the student have? _____

_____

_____

We adopt appropriate data collection, storage and processing practices and security measures to protect against unauthorized access, alteration, disclosure or destruction of your personal information. Please consult our Privacy Policy for full details:
https://www.manorhouseschool.com/Privacy

Are there any known triggers for the seizures? Please list.

What typically happens when the student has a seizure?

How long does the seizure or seizures usually last?

Does he or she have a warning (aura)?

What kind of first aid, if any, is required?

Does the student need to rest after a seizure and for how long?

Is a spare set of clothing required to be kept on the school/college premises and if so where is this kept?

Does the student have sleep seizures which could affect attendance or functioning?

ROUTINE MEDICATION

How often does the student take medication each day ?

Is it necessary to take it in school/college and at any specific times?

Who is to be responsible for keeping and administering medication?

Does the medication have any side effects? What are these?

Does the student require emergency medication?

Has the Emergency Medication Protocol included been completed?

Does the student have any sensitivity to flashing lights or glare or photosensitive triggers? (EEG record can be checked if not known)

Does the student use any of the following aids or appliances, seizure alarm or smartwatch, helmet, ventilated pillow, other ?

What does the student wish staff and/or students to know about their epilepsy and seizures?

Does the student wish to be involved in any education sessions on epilepsy?

OTHER CONDITIONS

Does the student have any other conditions apart from epilepsy?

Has the medical team(s) advised any limitations on activities?

Does the student have an understanding of their condition(s) and treatment?

Are there any other special considerations?

MHS CONSENT FORMS FOR EPILEPSY CARE PLAN INFORMATION

I _____ (parent/guardian/student) agree /do not agree that the medical guidance and information in this Epilepsy Care Plan can be made available to persons involved in the education and care of me/my child and to the emergency services when required.

Signed by Parent/Guardian/Student _____

Date _____

CONSENT FOR ADMINISTRATION OF EMERGENCY MEDICATION

In a seizure related emergency I consent/do not consent to having emergency medication administered to my child/me by a member of staff or having the appropriate first aid given as outlined in the Epilepsy Care Plan

Signed by Parent/Guardian/Student _____

Date _____

The school/college may/may not contact those medical or other professionals below for further information or training. The Parent or Student undertake to give/not give consent to medical teams to provide medical information to the school/college

Name(s) _____

Contact numbers _____

MHS MEDICATION/EMERGENCY MEDICATION ADMINISTRATION RECORD

ROUTINE MEDICATION

Student Name: _____

Date: _____

Dose administered _____

Time Administered _____

Notes eg, ambulance called _____

Name of staff member _____

Signed _____

EMERGENCY MEDICATION

Student _____ Date _____

Dose Administered _____

Time Administered _____

Route _____

Response to emergency medication _____

Notes eg. first ever dose, ambulance called _____

Name of staff member _____

Signed _____