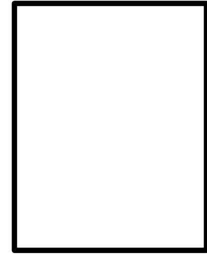
Covenant Christian School
All knowledge through Christ



Epilepsy Care Plan 2019

To be completed by parent or guardian

Student Details		
Surname:	Given Name:	
Class:	Date of Birth:	❐ Female ❐ Male
Mother's Name:	Ph (H):	Ph (M):
Father's Name:	Ph (H):	Ph (M):
Other Emergency Contact:		
Name:	Relation:	Contact No.
Doctor's Name:		Ph:

Details of Condition

Type of epilepsy

____

Please describe type of seizures experienced

____

____

____

Are seizures likely to occur at school? ❐ Yes ❐ No

If yes, how frequently?

____

Are there any factors of situations that may trigger seizures? ❐ Yes ❐ No

If yes, please describe

____

____

Are there any limitations on participating in school activities? ❐ Yes ❐ No

If yes, please give details (including additional supervision required):

____

Details of Managing the Condition

If your child had a seizure at school, what should school staff do? Please describe procedure in detail:

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____

Under what circumstances, should the doctor/ambulance be called? Please state clearly.

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Is your child taking any medication for epilepsy? ❒ Yes ❒ No

If yes, please complete the following and a medication administration form if appropriate:

Name of medication: ______________________________ Strength: __________________________

Dosage: _________________________ Time to be taken: ___________________

Any further comments/information:

____

____

____

Name of Parent/Guardian: ________________________________

Signed: ___________________________ Date: _______________