THIS GUIDELINE DESCRIBES THE MANAGEMENT OF

Epilepsy

IN THE SCHOOL SETTING INCLUDING THE ROLE OF COMMUNITY CHILD HEALTH MEDICAL AND PUBLIC HEALTH NURSING SERVICES

This guideline is designed to assist both health-care and non-health-care personnel involved in the care of children

This guideline should be read in conjunction with the Administration of Medicines in Schools Policy

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Prepared by: Alison MacRobbie Date of Review 1st May 2015
Lead Reviewer: Roald Dahl Children’s Epilepsy Liaison Nurse Jan.mackenzie2@nhs.net
Lorraine.simpson@rah.scot.nhs.net tel 0141 887 9111
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Distribution

- Medicines in Schools Steering Group & Website
- Public Health Nurses
- Health Visitors
- Consultant Paediatricians
- Consultant Community Paediatricians
- Paediatric Clinical Nurse Specialists
- Paediatric Pharmacists
- Community Pharmacists
- GPs
- Children’s Ward
- Children’s Services Lead Nurses Health and Education
- Education & Leisure Services The Highland Council and Argyll & Bute Council
- Support for Educational Needs Staff
- School Head Teachers
- Early Years leads
- Early Years providers
- The Orchard
- Children’s Commissioner

Method
CD Rom ✗ E-mail ✓ Paper ✓ Internet ✓
### Description of condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
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<tbody>
<tr>
<td>Epilepsy</td>
<td>Epilepsy is the tendency to have repeated seizures that originate in the brain. The neurons (nerve cells) in the brain are responsible for a wide range of functions including consciousness, awareness, movement and bodily posture. A sudden, temporary interruption in some or all of these functions may be termed as a seizure. Epilepsy can begin at any age but it often starts in childhood. Although some people believe it is always linked with physical or learning disabilities, this is not the case but it is common in association with learning disabilities.</td>
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**GENERALISED SEIZURES**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Absence seizures</td>
<td>These involve a brief loss of awareness for seconds (perhaps 5 - 20 seconds) and can occur many times a day. The child stops what they are doing and stares, blinks or looks vague for a few seconds. Occasionally there will be lip smacking, gulping or a repetitive movements, before carrying on with what he/she was doing. An onlooker may simply think they are daydreaming or may not even notice. Girls experience them more than boys.</td>
</tr>
<tr>
<td>Myoclonic seizures</td>
<td>These involve sudden jerky or shock-like contractions of different muscles, usually in the arms or legs, with a momentary loss of consciousness and quick recovery (like the sudden jerk most of us have experienced when falling asleep).</td>
</tr>
<tr>
<td>Atonic seizures</td>
<td>These involve sudden loss of muscle tone, sudden relaxation of the muscles, resulting in a fall. They often result in a head injury, with the person striking a table or desk in the fall. An atonic seizure usually lasts for a few seconds and may be preceded by a very brief myoclonic seizure.</td>
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<tr>
<td>Tonic seizures</td>
<td>These involve sudden stiffness of the limbs or whole body, again leading to a fall. The seizure usually lasts for 5 – 10 seconds.</td>
</tr>
<tr>
<td>Tonic-clonic seizures</td>
<td>This is the most common sort of generalised seizure which involves all or most of the brain. It is the one most of us think of when we imagine someone having an 'epileptic fit'. The tonic part of the seizure refers to when the...</td>
</tr>
</tbody>
</table>
### What might happen –

A person goes stiff. This happens because all the body’s muscles contract. Sometimes the person appears to cry out because the muscles in the lungs also contract, forcing out air. Breathing may become irregular with the result that there is not enough oxygen in the lungs, their face may look pale with a bluish tinge around the lips due to the lack of oxygen. There may be incontinence of urine or faeces.

After the tonic phase has passed, the clonic phase of the seizure begins. This refers to the jerking movements. The limbs jerk because now the muscles contract and relax in quick succession. No attempt should be made to restrict the person’s movements as this could cause damage to their limbs. After a few minutes the jerking movements slow down and then stop. A period of drowsiness, confusion, headache and sleep often follows.

The whole seizure may only last a minute or two, but if the seizure lasts more than 5 minutes or if it is the first time the person has had a seizure, or if injury has occurred, medical assistance should be sought at once.

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### FOCAL SEIZURES

Formerly known as partial/simple partial/complex partial/secondary generalised seizures. These occur when the abnormal electrical activity starts in one part of the brain.

There are two types of seizures.

1. **Someone’s level of consciousness is not affected during the seizure but it may involve a change in sensation such as a strong (often unpleasant) smell or taste, unexplained fear or feeling of déjà vu or even tingling and numbness in the face or an arm. The sensations felt are determined by in which area of the brain the seizure started.**

2. **The second type is when consciousness or awareness is affected – the person may look confused or dazed or behave and act in a strange way, become unresponsive and start to perform inappropriate or automatic movements. Possible behaviours are, plucking at clothes; picking up and placing things down; wandering or running aimlessly; lip smacking; slurred speech.**
Photosensitive epilepsy

Seizures vary from person to person but are most often generalised tonic-clonic attacks, absences or myoclonic jerks.

Photosensitivity means being sensitive or susceptible to flashing or flickering lights but only when the flashes or flickers occur at a certain frequency.

Both artificial and natural light sources can trigger seizures. Intensity of light can be a factor; sunlight shining off water or flickering through the leaves of trees or railings. Polarised sunglasses, preferably with side shades, can help to reduce the flicker effect.

Television

TV is the most commonly reported trigger of seizures in photosensitive people. The distance of the person from the TV is the most important factor. The closer the person is to the set, the more the screen fills the entire field of vision and so the greater visual effect on the brain.

Simple precautions can be taken:

- Sit at least 3m away from the TV
- Sit level with, not below, the screen.
- Place a subdued light on top of the set to counteract the brightness of the screen, even whilst watching during daylight hours.
- Place a hand over one eye to lessen the effect of the flicker when operating the controls of the TV, since binocular vision (involving both eyes) is necessary to trigger a seizure.
- A small TV screen is preferable to a large one.

Video Games

Current medical opinion is that video games do not create a tendency to epileptic seizures when the tendency is not already in existence. However, games featuring patterns of flashing lights can cause isolated seizures in a very small number of photosensitive people, depending on the nature of the flickering lights.

It is also possible that sustained and intense
concentration whilst playing video games may generate stress, which in turn may make a seizure more likely.

**Computer Visual Display Units (VDUs)**

There is no evidence to suggest that VDUs can actually cause epilepsy, although seizures may be provoked in a small number of people who already have a sensitivity to the flicker effect of the screen.

Computer work does not necessarily need to be restricted, though sustained and intense concentration may be stressful and may trigger a seizure.

It is possible to get a screen cover to minimise flicker. Some screen background colours (eg. green) are preferable to others.

**Discos**

Most young people who have epilepsy are not photosensitive and can enjoy discos, although excessive heat and noise may make seizures more likely. The degree of risk will depend on the speed at which the lights are flashing often 12-30 flashes per second.

If a strobe light should suddenly be switched on, its effects can be reduced by covering one eye with your hand – closing one eye will not be enough as light can pass through closed eyelids.

<table>
<thead>
<tr>
<th>Triggers/precipitating factors</th>
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<tbody>
<tr>
<td>Illness</td>
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<td>Fever</td>
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<tr>
<td>Constipation</td>
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<td>Menstruation</td>
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<tr>
<td>Stress</td>
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<tr>
<td>Boredom</td>
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<tr>
<td>Tiredness due to late nights</td>
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<tr>
<td>Missed medication or non-adherence of medication</td>
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**Medication**

Treatment of epilepsy is primarily with anti-epileptic (anticonvulsant) drugs which aims to create a balance between the prevention of seizures and the minimisation of side effects, so that the child has a good quality of life.

It is good practice to allow pupils who can be
<table>
<thead>
<tr>
<th>Ketogenic Diet</th>
<th>Vagus Nerve Stimulator</th>
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<tbody>
<tr>
<td>The Ketogenic Diet is an individually calculated high fat, low carbohydrate,</td>
<td>When two or three drug treatments have been tried without success, children who</td>
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<tr>
<td>restricted protein diet which can be used in epilepsy, for children who have</td>
<td>have difficult to control epilepsy may be considered for a Vagus Nerve Stimulator.</td>
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<tr>
<td>difficult to control epilepsy. Specialist Dietitians manage ketogenic diets. This</td>
<td>This treatment is child-specific, involves brain surgery and is in consultation with</td>
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<tr>
<td>treatment is child-specific and is in consultation with the Paediatric Neurologist</td>
<td>the Paediatric Neurologist and Paediatrican.</td>
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<tr>
<td>and Paediatrician.</td>
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<tr>
<td>All emergency medication should be kept in an identified locked cupboard and</td>
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<tr>
<td>staff who have been trained to administer the medication should know where to</td>
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<td>access the key in an emergency.</td>
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<tr>
<td>Any previous or out of date individual guidelines should be removed and kept</td>
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<tr>
<td>in the child’s file.</td>
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<tr>
<td>The child’s current medication, emergency medication guideline, a copy of the</td>
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<tr>
<td>training guidelines and gloves should be kept together.</td>
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<tr>
<td>Only staff who have up-to-date training, can administer emergency medication.</td>
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<tr>
<td>Care should be taken in the checking procedure before giving medication as</td>
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<td>discussed in training – preferably 2 colleagues to check.</td>
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<tr>
<td>Recording sheets which are kept with the training guidelines should be completed.</td>
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<tr>
<td>Parents/carers must be informed if medication has been given, as per guidelines.</td>
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<tr>
<td>( see template individual healthcare plan for emergency treatment details using</td>
<td></td>
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<tr>
<td>Midazolam)</td>
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</table>

Emergency medication in the treatment of prolonged or recurrent seizures:

- **Epistatus® 10mg/1ml** – the dose of which is calculated on the weight of the child by the paediatrician/epilepsy nurse.

For Highland Council Partnership Area:
Refer to Highland Council and NHS Highland administration of Buccal Midazolam Policy

- Rectal Diazepam is prescribed for children who are under 15Kg weight.

- Children or young people who have difficult to control epilepsy may require Rectal Paraldehyde, as detailed in their emergency medication guideline.

Parents/carers must be informed if medication has been given, as per guidelines.
( see template individual healthcare plan for emergency treatment details using Midazolam)
Requirements at school

Teachers and staff who work with children who have epilepsy, should be made aware of their condition as they can provide discreet and systematic monitoring of any seizures in class. It is important there is effective communication with parents/carers and the use of a seizure diary could be considered.

Parents can provide teachers with helpful information, which will be useful in the day to day management of a child who has epilepsy. Helpful questions to ask parents/carers:

- What kind of seizures does the child have and what are the signs to look for?
- How long do seizures last?
- How often do seizures occur?
- Does the child have any warning of a seizure coming on?
- Are there any special conditions or events known to trigger seizures?
- How often does the child take medication and is it necessary to take any in school?
- Does the child experience any side effects from the medication?
- What kind of first aid is likely to be required?
- How long a rest period does the child usually need after a seizure?
- Is the child likely to be incontinent during a seizure?
- Does the child have any other kind of disability?
- Does the child have an understanding of epilepsy and treatment for seizures?
- Have they any restrictions to the child’s activities at school?
- If the child needs emergency medication is there a written care plan/guidelines, in place?

Escorts

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- Does the child have any other kind of disability?
- Does the child have an understanding of epilepsy and treatment for seizures?
- Have they any restrictions to the child’s activities at school?
- If the child needs emergency medication is there a written care plan/guidelines, in place?

Education Authorities arrange home to school transport where legally required to do so, with a responsibility to:

- Provide safe transport
- To provide appropriate training to escort staff in Epilepsy Awareness.
- If considered necessary, a mobile phone should be provided as a means of
<table>
<thead>
<tr>
<th>Complications at School/pre-school</th>
<th>Management of seizures</th>
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</thead>
<tbody>
<tr>
<td>Children with epilepsy may have seizures during the school day causing a degree of risk that must be managed. Seizures may appear frightening to other children and staff due to fear, ignorance and stigma which is attached to this condition. Staff have a role to play in minimising the socially harmful effects of a seizure. Having knowledge of the child’s type of seizures is essential and can help the teacher to deal with it appropriately.</td>
<td>There is no need to call a doctor or ambulance unless</td>
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<td>• It is the child’s first seizure known to you.</td>
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<td></td>
<td>• One seizure follows another without any recovery in between.</td>
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<td></td>
<td>• The seizure lasts more than 5 minutes or is longer than usual for the child.</td>
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<td></td>
<td>• The child has been injured.</td>
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<td></td>
<td>• A seizure has happened in the pool and the child might have swallowed or inhaled too much water.</td>
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<tr>
<td>First aid for dealing with seizures other than tonic-clonic seizures</td>
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<tr>
<td>First aid for dealing with tonic-clonic seizures</td>
<td>• Stay with the child, keep calm and time commencement of seizure.</td>
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<td></td>
<td>• If possible, seek help from a colleague to deal with other children in the class.</td>
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<tr>
<td></td>
<td>• If the child has sustained a head injury, seek medical assistance.</td>
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<tr>
<td></td>
<td>• Stay with the child until the seizure has ended to ensure they do not suffer any further injury.</td>
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<tr>
<td></td>
<td>• Reassure the child as they recover.</td>
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<td></td>
<td>• Inform the parents/carers as soon as convenient.</td>
</tr>
<tr>
<td>DO</td>
<td>• Keep calm.</td>
</tr>
<tr>
<td></td>
<td>• Seek help from a colleague to deal with other children in the class.</td>
</tr>
<tr>
<td></td>
<td>• Time commencement of a seizure.</td>
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<tr>
<td></td>
<td>• Give the child privacy, clear a space and prevent others from crowding round.</td>
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<tr>
<td></td>
<td>• Cushion the head eg. with rolled up jumper</td>
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</tbody>
</table>
or jacket.
- Loosen any restrictive clothing eg. tie or belt.
- Remove the child’s glasses if worn.
- Do not restrain the person - Let the seizure run its course.
- Do not put anything in the mouth.
- When convulsion is over, put the child into the recovery position, on their side, so that the mouth can drain of saliva or vomit.
- Time when the convulsion ended.
- Reassure the child when he/she comes round as they may be confused and have no memory of what has happened.
- Stay with the child.
- Give the child a chance to rest. There can be an overwhelming desire to sleep.
- Take as accurate a history of the event as possible.
- Let the child’s parents/carers know about the seizure.

Do not
- Leave the child unattended.
- Lift or move the child while the seizure is happening unless there is immediate danger.
- Try to restrain the child’s movements.
- Put anything in between the teeth. Or into the mouth.
- Offer the child something to drink or eat.
- Fuss around the child. Be discreet and give the child their space and dignity.

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**Swimming**

Member of staff, lifeguard or pool supervisor should be made aware that a child has epilepsy.

**It is important staff are made aware of how the child’s seizures present.**

- Not all children with epilepsy have convulsions.
- The child may have absences and appear to be daydreaming.

**How to deal with a seizure in the water**

- Absence and partial seizures do not usually need emergency action.
- Child should be protected from danger and closely supervised.
- In the event of a tonic-clonic seizure, hold the child’s head above water from behind.
- If possible move the child to shallow water, holding their head above water.
- Do not restrict movement or place anything in the mouth.
- Once the abnormal movement has stopped, with assistance, transfer the child to the side of the pool.
- Place the child on their side to recover.
- Remain with the child until they recover.

**Call an ambulance if**
### Safety in swimming

In swimming, a 'buddy system' where the children swim in pairs or a senior pupil is designated to 'buddy' the child, is another safety precaution.

- Children who have partial seizures may appear confused or make repeated movements.
- You think the child has swallowed or inhaled water.
- The child goes into another seizure without regaining consciousness.
- The seizure lasts longer than is usual for the child, or when the seizure has lasted for 5 minutes.
- There has been an injury.

If an ambulance has been called, it would be helpful to provide information to the paramedics eg:

- Seizure type, if known or description of seizure.
- When the seizure started.
- How long the seizure lasted.
- If the child has an Individual Epilepsy guideline, was emergency medication given and what it was?
- Time of administration of medication
- Time if a second dose was required.

### School/Pre-school trips

Epilepsy should not prevent a child from participating in school trips although additional safety measures may need to be taken into account when planning outings.

It is the responsibility of the school/pre-school to ensure a child who has been prescribed emergency medication, is supported by a trained member of staff in community activities. The staff member would be responsible for carrying and safekeeping of the medication and the child/young person’s individual care plan/guidelines.

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## Responsibility of Organisations

<table>
<thead>
<tr>
<th>Health</th>
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<tbody>
<tr>
<td>There will be a school doctor for each school in the area.</td>
<td>There will be a public health nurse for each school.</td>
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<tr>
<td>There will be a Health Visitor for children in pre-school settings</td>
<td>Health services, including the Children’s Epilepsy Liaison Nurse, will provide relevant training to school staff on the management of children who have epilepsy. In particular, individual guidance in the management of a child who has been prescribed emergency medication for difficult to control seizures will be given.</td>
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<tr>
<td></td>
<td>Liaise in provision of relevant clinical guidance.</td>
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<td></td>
<td>Contribute to Child’s Plan as appropriate</td>
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<td>Ensure relevant staff receive appropriate training.</td>
<td>Ensure appropriate facilities and procedures are in place in education environments to manage children with epilepsy.</td>
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<td>Liaise with parents in relation to sharing information on health and medicine requirements for their children.</td>
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## Responsibilities of personnel involved

### Community Paediatricians

School paediatricians should be aware of all children who have epilepsy in their schools.

In partnership with the Children’s epilepsy liaison nurses should contribute to the development and delivery of education sessions for staff within schools and provide assistance to develop health care plans for individual children.

Liaise with the Children’s Epilepsy Liaison Nurse.

Liase with parents and other agencies involved in the care of the child who has epilepsy within a multi-disciplinary team.

Contribute to Child’s Plan as appropriate.

### Community and Hospital Paediatricians

School paediatricians should be aware of all children who have epilepsy in their schools.

In partnership with the Children’s epilepsy liaison nurses should contribute to the development and delivery of education sessions for staff within schools and provide assistance to develop health care plans for individual children.

Liaise with the Children’s Epilepsy Liaison Nurse.

Liase with parents and other agencies involved in the care of the child who has epilepsy within a multi-disciplinary team.

Contribute to Child’s Plan as appropriate.

### Public Health Nurses

Should ensure:
- teachers are aware of children who have epilepsy in their school/schools
- information and leaflets on epilepsy are up to date.
- problems or concerns are referred to school doctor and/or epilepsy nurse.
- Ideally there is a data base of names of children who have epilepsy and emergency medication.
- they liaise with community paediatricians and epilepsy nurse, as appropriate.
- Contribute to Child’ Plan as appropriate

### Children’s Epilepsy Liaison Nurse

Give support, education, advice and training into the child/young person’s home, school, nursery and leisure pursuits, including respite care.

Provide up to date information on epilepsy, advice and support when required.

Contribute to the construction of clear pathways at times of transition.

Aim to improve epilepsy control through liaison with the child and family and all professionals involved in their care.
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
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</table>
| Parent | Inform the school of their child’s condition, symptoms and treatment.  
Keep school information current  
Contribute to the Child’s Plan as appropriate  
Provide school with prescribed medication as appropriate.  
Ensure school has an adequate supply of emergency medication ie Rectal Diazepam, Buccal Midazolam(Epistatus®)/Buccolam® or Rectal Paraldehyde. |
| Education staff eg. teachers, nursery staff, auxiliaries, | Attend Epilepsy Awareness training.  
Adopt an individual approach to the child who has epilepsy.  
Find out how the child’s seizures present and symptoms to look for.  
Have good communication with parents/carers and keep them informed.  
Liaise with school paediatrician, children’s epilepsy liaison nurse and Named Person. |
## Requirements for implementation

| Training Health Staff | • Continuing professional development  
|                       | • Attend training on Epilepsy Awareness sessions to keep up with current best practice on health and first aid in the management and recognition of seizures  
|                       | • A brief up-date in emergency medication to be given after 1 year, then bi-annually.  
|                       | • Liaison with health staff or within a multi-disciplinary team.  
|                       | • Specific training on individual children when need arises.  
|                       | • Training to be provided by community child health staff, including Children’s Epilepsy Liaison Nurse. |
| Training School and social work staff | • Update on Epilepsy Awareness required every 2 years to keep up with current best practice in recognition and management of seizures.  
|                                       | • Emergency medication refresher required after 1 year, then bi-annually.  
|                                       | • Specific training on individual children required as need arises.  
|                                       | • Training to be provided by community child health staff, including school nurses and Children’s Epilepsy Liaison Nurse. |
| Equipment/facilities | • Secure storage, a locked cupboard for medication is required.  
|                      | • This facility must be identifiable and readily accessible to appropriate trained staff.  
|                      | • Medication must be delivered to the school in the original container, with the child’s prescription label clear and legible.  
|                      | • Expiry date should be checked. |
| Documentation | • Up-to-date Individual Care Plans/Guidelines in the management of emergency medication.  
|               | • Record of medication administered.  
|               | • Seizure recording sheets.  
|               | • Individual epilepsy care plan as part of the Child’s Plan (How I Grow and Develop section)  
|               | • Child’s plan indicated responsibilities of all parties and levels of support offered with links to the Child health Care Plan |
Referral and liaison

Referrals from the hospital paediatricians or community paediatricians (includes all correspondence).

Referrals to the Children’s Epilepsy Liaison Nurse can be made via the school doctor.

Liaison is particularly important at the time of school entry, transfer to secondary school, transfer to an other school and transition.

Exceptions

- When school/pre-school are not advised by parents of a child’s condition.
- Staff member declines to provide treatment/administer medication

In these instances it would be appropriate to contact the child’s parents or phone for medical assistance.

References

SIGN Guidelines in Diagnosis and Management of Epilepsies in children and Young People N0 81—www.sign.ac.uk

Policies in place in school e.g. The administration of medicines in school, child protection, health and safety, consent (if the child is of 12 years of age or greater and has the capacity to make decisions relating to the management of their condition, he/she has the right to make choices).
Appendix 1

Staff agreeing to administer medicines

The head teacher is responsible for ensuring that staff agreeing to administer medicines obtain the recommended training to do so and for maintaining and up-to-date record of such persons.

The staff member administering medicines is responsible for ensuring that he or she understands and is competent to undertake the duties required. The staff member is also responsible for ensuring that administration is carried out as described in the policy and according to his or her code of professional practice and conduct.

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