LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la Santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

PAI - Individualised Support Plan
EPILEPSY

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1. Input

Fields marked with an * are mandatory

Identity of the applicant

Photo

ONLY for School Medical Service:

Child's/Student's family name(s):*

Child's/Student's first name(s):*

Nat. identification number(matricule):*
(or date of birth if no id number)

Cycle / class:

School/SEA:*

Place/Location:*

Name(s) of legal representative/parents:*

Address:*

Telephone:

Email address:

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Delegation of care

Fields marked with an * are mandatory

I,* _____

the undersigned, legal representative or adult student, request for my child or myself the implementing of an Individualised Support Plan (PAI) based on the medical prescription and emergency intervention protocol established by

Dr* _____

I authorise that this document be made known and applied by the people in charge of the student/child or myself : school, school health team, day care centre/SEA, SePAS.
It is my responsibility:

- to check the expiry date of medicines
- to replace them as soon as they reach the expiry date
- in the event of a change in the medical prescription, to inform the people responsible for the child/student and the school health team

Signature (mandatory)

Place:* _____

Date:* _____

Signature of legal representative or adult student:* _____

Prescribing physician

Name:* _____

Date:* _____

Signature:* _____

For the doctor at the National Health Directorate - Department for School Medicine and Health of Children and Young People

PAI received on: _____

forwarded to: _____

on: _____

Signature: _____

MSA_DSA_PAI-EP_E_202002_0

Child's/Student's family name(s): _____ Nat. identification number: _____

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2. Supervisory staff

School health team	Name	Job title	Tel. no.
Headteachers	Name	Job title	Tel. no.
Supervisory staff at day-care centre	Name	Job title	Tel. no.
SePAS/ESEB	Name	Job title	Tel. no.
Others	Name	Job title	Tel. no.

3. Doctors treating the child

Family doctor (GP)	Name	Address	Tel. no.
Specialists	Name	Address	Tel. no.

Child's/Student's family name(s): _____ Nat. identification number: _____

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4. Transmission of the PAI / Concertation meeting

Information session:

Date:

Attendance list - People who have knowledge of the PAI

(give names and job titles of all people who have knowledge of the PAI)

Job title	Family name/First name	Signature	Date
Head teacher			
Educator			
Person in charge of the day-care centre			
Staff at day-care centre			
SEPAS			
ESEB			
Others			
Others			
Others			

For the School Health Team

A copy of the PAI has been handed to:

Date:

IMPORTANT: Instructions for staff responsible for the child/student:

- **Please inform the school principals in basic/secondary education establishments, the teachers, the supervisory staff and the supply teachers of the existence of this document.**
- **Send a copy of this page to *Division de la Médecine scolaire* (by post to: 20 Rue de Bitbourg, L-1273 Luxembourg-Hamm, or by email to pai@ms.etat.lu) after the people concerned have read the PAI and their signatures have been obtained.**

Child's/Student's family name(s): Nat. identification number:

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5. EMERGENCY ACTION PLAN - EPILEPSY

IN THE EVENT OF AN EPILEPTIC SEIZURE:

Symptoms:

- ☐ Seizure/rhythmic jerking
- ☐ Loss of consciousness
- ☐ Absence (lapses in awareness, isolated and short-term)
- ☐ Short motor automatisms (repeated movements)
- ☐ _____
- ☐ _____

What you should do: Keep calm, most seizures end spontaneously after just a few minutes!!

- prevent the child from getting hurt
- loosen the child's clothing to make breathing easier
- place a cushion under the child's head
- don't put anything in the child's mouth
- keep an eye on the time to know how long the seizure lasts
- keep other children at a distance

If the seizure lasts more than _____ minutes:

1. Administer the following medication:

- ☐ _____
- ☐ _____
- ☐ _____

2. ☐ Call the SAMU emergency service (112) straight away

☐ Call the SAMU emergency service (112)

- **if the seizure lasts more than 5 minutes after the medicine is administered**
- **In case of a relapsing seizure in a short time**
- **If the pupil/student was injured during the seizure, or if the seizure occurred at the swimming pool**
- **If the pupil/student doesn't recover normally after the seizure (sleepy, can't be woken)**

If you are unsure, DO NOT HESITATE TO CALL THE SAMU EMERGENCY SERVICE

3. Inform the PARENTS

Signature

Place:* _____

Date:* _____

Stamp of the doctor:* _____

Child's/Student's family name(s): _____ Nat. identification number: _____

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6. Instructions

1. Emergency kit

PLACE A COPY OF THIS DOCUMENT IN THE EMERGENCY KIT

Content / Medicines	Expiry date

Location	
School ☐	
Day-care centre/SEA ☐	
Other ☐	

- **IF THE SAMU EMERGENCY SERVICE IS CALLED, INFORM THEM OF THE EXISTENCE OF THIS DOCUMENT**
- **INFORM THE PARENTS**
- **THE EMERGENCY KIT MUST FOLLOW THE CHILD ON ALL JOURNEYS OUTSIDE THE SCHOOL**

2. Conditions for support :

Physical activities	Swimming	Excursions and other activities
☐ not allowed	☐ not allowed	☐ no restrictions
☐ close supervision	☐ close supervision [1]	☐ close supervision
☐	☐	☐

1) An adult person able to watch the pupil/student from the side of the pool and who is capable of getting the pupil/ student out of the water or calling for help quickly; the pupil/student must be clearly visible (swimming cap in a noticeable colour)

3. Any other arrangements:

Signature

Place:*

Date:*

Stamp of the doctor:*

Child's/Student's family name(s):

Nat. identification number: