



Skills for Growing Up – Epilepsy ‘Almost there’

17 year or older





The Skills for Growing Up – Epilepsy is based on the Dutch Skills for Growing Up tool developed by the University Medical Center Groningen, Rehabilitation Center Blixembosch, Mytyschool Eindhoven, Erasmus Medical Center Rotterdam and TransitieNet on the basis of the original Skills for Growing Up (Holland Bloorview Kids Rehabilitation Hospital in Toronto, Canada). The icons used are developed by Op Eigen Benen in collaboration with TransitieNet

Me			Date:	Date:	Ready
					V
1	I think about how I can be independent in our family	Yes / No	Yes / No	<input type="checkbox"/>	
2	I think about how I can get by financially in the future	Yes / No	Yes / No	<input type="checkbox"/>	
3	I can stand up for myself in the places I routinely visit (school, home, shops, library, sports club, online)	Yes / No	Yes / No	<input type="checkbox"/>	
4	I have somebody with whom I can discuss personal matters if something is bothering me	Yes / No	Yes / No	<input type="checkbox"/>	
5	I know my talents	Yes / No	Yes / No	<input type="checkbox"/>	
6	I'm satisfied about my appearance	Yes / No	Yes / No	<input type="checkbox"/>	
7	I can tell others what I have and what are the practical implications for me (friends, at school / work, family)	Yes / No	Yes / No	<input type="checkbox"/>	
8	There's always somebody nearby who knows about my epilepsy and its consequences	Yes / No	Yes / No	<input type="checkbox"/>	
9	I know the consequences of my disability for my (health) insurance	Yes / No	Yes / No	<input type="checkbox"/>	


Healthcare			Date:	Date:	Ready
					V
1	I eat healthy	Yes / No	Yes / No	<input type="checkbox"/>	
2	I follow a diet and understand why I do	Yes / No	Yes / No	<input type="checkbox"/>	
3	I know why smoking, alcohol and drugs are dangerous for my health	Yes / No	Yes / No	<input type="checkbox"/>	
4	I know which medications I can use for minor problems (a cold, headache)	Yes / No	Yes / No	<input type="checkbox"/>	
5	I can explain my medical history to others	Yes / No	Yes / No	<input type="checkbox"/>	
6	I share the decision of what care I need with my doctor	Yes / No	Yes / No	<input type="checkbox"/>	
7	I sign my own medical consent form	Yes / No	Yes / No	<input type="checkbox"/>	
8	I plan and manage my own visits to the doctor	Yes / No	Yes / No	<input type="checkbox"/>	
9	I go to healthcare visits alone, or decide who comes with me	Yes / No	Yes / No	<input type="checkbox"/>	
10	I ask most of the questions during healthcare visits	Yes / No	Yes / No	<input type="checkbox"/>	
11	I give most of the answers to questions during healthcare visits	Yes / No	Yes / No	<input type="checkbox"/>	
12	I have made plans for the transfer to the transition clinic or adult care	Yes / No	Yes / No	<input type="checkbox"/>	
13	I know what my health risks are if I do not follow the prescribed treatment	Yes / No	Yes / No	<input type="checkbox"/>	


14	I take my own medication	Yes / No	Yes / No	<input type="checkbox"/>
15	I know the possible side effects of my medications	Yes / No	Yes / No	<input type="checkbox"/>
16	I know the implications of fatigue for my epilepsy	Yes / No	Yes / No	<input type="checkbox"/>
17	I know the implications of stress for my epilepsy	Yes / No	Yes / No	<input type="checkbox"/>


Living and ADL			Date:	Date:	Ready
					V
1	I know that supervision is required when I take a bath or shower		Yes / No	Yes / No	<input type="checkbox"/>
2	I can make my own meals		Yes / No	Yes / No	<input type="checkbox"/>
3	I can do my own laundry		Yes / No	Yes / No	<input type="checkbox"/>
4	I manage my own money		Yes / No	Yes / No	<input type="checkbox"/>
5	I buy the things I need for myself		Yes / No	Yes / No	<input type="checkbox"/>
6	I know whether I can be home by myself		Yes / No	Yes / No	<input type="checkbox"/>
7	I think about my future living situation		Yes / No	Yes / No	<input type="checkbox"/>
8	I know where I can go for extra services		Yes / No	Yes / No	<input type="checkbox"/>


Relationships			Date:	Date:	Ready
					V
1	I participate in social and recreational activities for young people and adults		Yes / No	Yes / No	<input type="checkbox"/>
2	I do things with my friends in my spare time		Yes / No	Yes / No	<input type="checkbox"/>
3	I maintain friendships and relationships		Yes / No	Yes / No	<input type="checkbox"/>
4	I invite friends and family over to my house		Yes / No	Yes / No	<input type="checkbox"/>
5	I can make new contacts		Yes / No	Yes / No	<input type="checkbox"/>
6	I know what unhealthy intimate relationships are (lover boys)		Yes / No	Yes / No	<input type="checkbox"/>
7	I know about different contraceptives and how to obtain them		Yes / No	Yes / No	<input type="checkbox"/>
8	I know about the influence my epilepsy has on my sexuality		Yes / No	Yes / No	<input type="checkbox"/>
9	I know about the influence my epilepsy has on pregnancy/parenting and heredity		Yes / No	Yes / No	<input type="checkbox"/>
10	I know that epilepsy medication can have an influence on contraceptives (such as the pill)		Yes / No	Yes / No	<input type="checkbox"/>


11	I'm aware of the influence sexual arousal can have on my epilepsy	Yes / No	Yes / No	<input type="checkbox"/>
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Education			Date:	Date:	Ready
					V
1	I have made plans about what I will do when I am finished with school		Yes / No	Yes / No	<input type="checkbox"/>
2	I know my medication can cause concentration problems		Yes / No	Yes / No	<input type="checkbox"/>
3	I know where to get help in order to succeed in my education		Yes / No	Yes / No	<input type="checkbox"/>
4	I know how I can get an internship		Yes / No	Yes / No	<input type="checkbox"/>
5	I know what I can say about my epilepsy in an orientation interview or a job interview		Yes / No	Yes / No	<input type="checkbox"/>

Transportation			Date:	Date:	Ready
					V
1	I use public transportation on my own (bus, train, subway) or a taxi		Yes / No	Yes / No	<input type="checkbox"/>
2	I go out in traffic on my own (walking, biking)		Yes / No	Yes / No	<input type="checkbox"/>
3	I know if I am allowed to drive with my epilepsy		Yes / No	Yes / No	<input type="checkbox"/>
4	I go out in traffic on my own (scooter, car)		Yes / No	Yes / No	<input type="checkbox"/>

Sports			Date:	Date:	Ready
					V
1	I maintain a healthy lifestyle and sufficient exercise: playing sports/working out, cycling to school/job		Yes / No	Yes / No	<input type="checkbox"/>
2	I belong to a sports team or a gym		Yes / No	Yes / No	<input type="checkbox"/>
3	I know certain sports can be dangerous because of my epilepsy (such as swimming without supervision)		Yes / No	Yes / No	<input type="checkbox"/>

Leisure activities			Date:	Date:	Ready
					V
1	I go out with others		Yes / No	Yes / No	<input type="checkbox"/>
2	I know that staying out late can have consequences for my epilepsy		Yes / No	Yes / No	<input type="checkbox"/>
3	I know certain club lighting systems can have an influence on my epilepsy, and what I can do about it		Yes / No	Yes / No	<input type="checkbox"/>
4	I can go on holiday by myself		Yes / No	Yes / No	<input type="checkbox"/>
5	I seek out and/or participate in activities in my (new) living environment		Yes / No	Yes / No	<input type="checkbox"/>

Work			Date:	Date:	Ready
					V
1	I have volunteer work, a vacation job or a (regular) job		Yes / No	Yes / No	<input type="checkbox"/>
2	I know what I wish to achieve in my (future) work and/or study		Yes / No	Yes / No	<input type="checkbox"/>
3	I know where I can get help in order to do my job well		Yes / No	Yes / No	<input type="checkbox"/>
4	I know who can help me find work		Yes / No	Yes / No	<input type="checkbox"/>
5	I know how my epilepsy influences my work		Yes / No	Yes / No	<input type="checkbox"/>