Date form completed_____
Date for review_____
Copies held by_____

HEALTHCARE PLAN

For pupils with medical conditions at school

1. Pupil's Information

Name_____ Date of Birth_____

Class _____ Male ☐ Female ☐

Member of staff responsible for home/school communication: _____

2. Contact Information

Pupil's address _____

_____ Postcode: _____

Family contact 1

Name _____

Phone (day) _____ Mobile _____

Phone (evening) _____ Relationship with child _____

Family contact 2

Name _____

Phone (day) _____ Mobile _____

Phone (evening) _____ Relationship with child _____

GP

Name _____ Phone _____

Specialist Contact

Name _____ Phone _____

3. Details of pupil's medical condition

Signs and symptoms of this pupil's condition _____

_____

Triggers or things that make this pupil's condition/s worse _____

_____

_____

4. Routine healthcare requirements (e.g. dietary, nursing needs or before physical activity)

During school hours _____

_____

_____

Outside school hours _____

_____

_____

5. What to do in an emergency

_____

_____

_____

6. **Regular medication taken during school hours**

Medication 1	Medication 2
Name/type of medication (as described on the container)	Name/type of medication (as described on the container)
_____	_____
_____	_____
Dose and method of administration amount taken and how the medication Is taken, e.g. tablets, inhalers, injection)	Dose and method of administration (the (the amount taken and how the medication is taken, e.g. tablets, inhaler, injection)
_____	_____
_____	_____
_____	_____
When is it taken (time of day)?	When is it taken (time of day)?
_____	_____
Are there any side effects that could affect this pupil at school?	Are there any side effects that could affect this pupil at school?
_____	_____

_____ _____

Are there any contraindications
(signs when this medication should not be given)?
_____

_____

Are there any contraindications
(signs when this medication should not be given)?
_____

_____

Self-administration: can the pupil administer the medication themselves?
☐ yes ☐ no ☐ yes with supervision by:
Staff member's name _____

_____

Medication Expiry Date _____

Self-administration: can the pupil administer the medication themselves?
☐ yes ☐ no ☐ yes with supervision by:
Staff member's name _____

_____

Medication Expiry Date _____

7. **Emergency medication (please complete even if it is the same as the regular medication)**

Name/type of medication (as described on the container) _____

_____

_____

Describe what signs or symptoms indicate an emergency for this pupil _____

_____

_____

_____

Dose and method of administration (how the medication is taken and the amount) _____

_____

_____

Are there any contraindications (signs when medication should not be given?) _____

_____

_____

Are there any side effects that the school needs to know about? _____

_____

Self-administration: can the pupil administer the medication themselves?

☐ Yes ☐ no ☐ yes, with supervision by;

Staff member's name

_____

Is there any other follow-up care necessary? _____

_____

Who should be notified? ☐ Parents ☐ Specialist ☐ GP

8. Regular medication taken outside of school hours (for background information and to inform planning for residential trips)

Name/type of medication (as described on the container) _____

_____

Are there any side effects that the school needs to know about that could affect school activities?

_____

_____

9. Members of staff trained to administer medications for this pupil

Regular medication

_____

Emergency medication

_____

10. **Specialist education arrangements required (e.g. activities to be avoided, special educational needs)**

_____

_____

11. Any specialist arrangements required for off-site activities (please note that the school will send parents a separate form prior to each residential visit/off-site activity)

_____

_____

12. Any other information relating to the pupil's healthcare in school?

_____

_____

_____

Parental and Pupil Agreement

I agree that the medical information contained in this plan may be shared with individuals involved With my/our child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing.

Signed: _____ Date: _____
(pupil)
Print Name _____

Signed: _____ Date: _____
(parent)
Print name: _____

Healthcare professional agreement

☐ I agree that the information is accurate and up to date

Signed _____ Date: _____

Print name _____ Job title _____

Permission for emergency medication

☐ I agree that I/my child can be administered my/their medication by a member of staff in an emergency

☐ I agree that my child cannot keep their medication with them and the school will make the necessary medication storage arrangements

☐ I agree that I/my child can keep my/their medication with me/ them for use when necessary

Name of medication carried by Pupil: _____

Signed _____ Date _____

Head teacher agreement

It is agreed that (name of child) _____

☐ Will receive the above listed medication at the above listed time (see part 6)

☐ Will receive the above listed medication in an emergency (see part 7)

This arrangement will continue until _____

(either end date of course of medication or until instructed by the pupil's parents)

Signed: _____ Date: _____

6. Permission

I understand that I must deliver the medicine personally to the school office and collect any remaining medication when the course is complete. I accept that the school has the right to refuse to administer medication.

Name _____ Relationship to child _____

Signed _____ Date _____

For School office use: Date medicine returned to parent

_____