

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. Special dietary requirements (please note all allergies/intolerance information must be evidenced by a medical professional's letter/report before we are able to cater for the child's needs)

Outline of the allergy/intolerance _____

Date of professional medical review (if not specified on accompanying evidence)

4. 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 _____

5. Routine healthcare requirements (e.g.nursing needs or before physical activity)

During school hours _____

Outside school hours _____

6. What to do in an emergency

7. Regular medication taken during school hours

Medication 1

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)

When is it taken (time of day)?

Are there any side effects that could affect
this pupil at school?

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 _____

Medication 2

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

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)?

Are there any side effects that could affect
this pupil at school?

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 _____

8. 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

9. 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?

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

Regular medication

Emergency medication

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

12. 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)

13. 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: _____

14. 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
