HEALTHCARE PLAN

For pupils with medical conditions at school

Name of student: _____ Tutor Group: _____

Date of Birth: _____ Male ☐ Female ☐

Address: _____

_____ Post Code: _____

Contact information

Family contact 1:

Name: _____ Phone (Day) _____

Mobile: _____ Phone (Evening): _____

Relationship to pupil: _____

Family contact 2

Name: _____ Phone (Day) _____

Mobile: _____ Phone (Evening): _____

Relationship to pupil: _____

GP

Name: _____ Phone: _____

Specialist/Consultant contact

Name: _____ Phone: _____

Medical condition information

Details of medical condition(s)

Signs and symptoms of pupil's condition: _____

_____

_____

_____

Triggers or things that make this pupil's condition(s) worse: _____

_____

_____

_____

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

During school hours: _____

_____

_____

_____

Outside school hours: _____

_____

_____

_____

What to do in an emergency:

_____

_____

_____

_____

_____

Regular medication taken during school hours

Medication 1 Name/type of medication (as described on the container):

_____

_____

_____

Dose and method of administration 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 your child at school?

_____

_____

_____

Are there any contra-indications (signs when this medication should not be given?

_____

_____

_____

Self administration: can your child administer the medication themselves?

☐ yes ☐ no ☐ yes, with supervision

Medication expiry date: _____

Medication 2

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

_____

_____

_____

Dose and method of administration 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 your child at school?

_____

_____

_____

Are there any contra-indications (signs when this medication should not be given?

_____

_____

_____

Self administration: can your child administer the medication themselves?

☐ yes ☐ no ☐ yes, with supervision

Medication expiry date: _____

Emergency medication

(please complete even if it is the same as 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 contra-indications (signs when medication should not be given)?

_____

_____

_____

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

_____

_____

_____

Self-administration: can your child administer the medication themselves?

☐ yes ☐ no ☐ yes, with supervision

Is there any other follow-up care necessary? _____

_____

_____

_____

Who should be notified?

☐ Parents ☐ Specialist ☐ GP

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?

_____

_____

_____

Members of staff trained to administer medications for your child:

Regular medication: _____

Emergency medication: _____

Specialist education arrangements required:

(eg activities to be avoided, special educational needs)

_____

_____

_____

Any specialist arrangements required for off-site activities:

(please note the school will send parents a separate form prior to each residential visit/off-site activity)

_____

_____

_____

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 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 (if pupil is below the age of 16)

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 my child can be administered 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 my child **can** keep their medication with them for use when necessary.

Name of medication carried by pupil: _____

Signed: _____ Date: _____
Parent/guardian (or pupil if above age of legal capacity)

Headteacher agreement

It is agreed that (pupil) _____

- ☐ Will receive the above listed medication during school hours
- ☐ Will receive the above listed medication in an emergency

This arrangement will continue until _____ (either end date of course of medication or until instructed by the pupil's parents)