

Healthcare Plan for a Pupil with Medical Needs



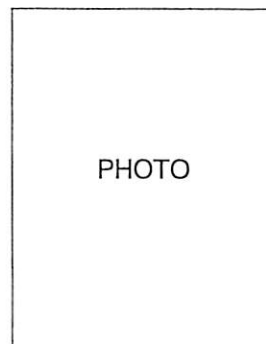
Name _____

Date of Birth _____

Condition _____

Class/Form _____

Name of School _____



Date _____

Review date _____

CONTACT INFORMATION

Family contact 1

Name _____

Phone No. (work) _____

(home) _____

Relationship _____

Family contact 2

Name _____

Phone No. (work) _____

(home) _____

Relationship _____

Clinic/Hospital contact

Name _____

Phone No. _____

G.P.

Name _____

Phone No. _____

Describe condition and give details of pupil's individual symptoms:

Form copied to:

Who is responsible in an Emergency: (State if different on off-site activities)

Follow up care:

Describe what constitutes an emergency for the pupil, and the action to take if this occurs:

Daily care requirements: (e.g. before sport/at lunchtime)

Example form for parents to complete if they wish the school to administer medication

The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medication

DETAILS OF PUPIL

Surname: _____
Forename(s): _____
Address: _____
M/F: _____
Date of Birth: _____
Class/Form: _____
Condition or illness: _____

MEDICATION

Name/Type of Medication (as described on the container) _____
For how long will your child take this medication: _____
Date dispensed: _____
Full Directions for use:
Dosage and method: _____
Timing: _____
Special Precautions: _____
Side Effects: _____
Self Administration: _____
Procedures to take in an Emergency: _____

CONTACT DETAILS:

Name: _____
Relationship to Pupil: _____
Address: _____
I understand that I must deliver the medicine personally to [agreed member of staff] and accept that this is a service which the school is not obliged to undertake.
Date: _____
Signature(s): _____
Relationship to pupil: _____



Confirmation of the Head Teacher's agreement to administer medication

Example form for schools to complete and send to parent if they agree to administer medication to a named child

I agree that *[name of child]* will receive *[quantity and name of medicine]* every day at *[time medicine to be administered eg. lunchtime or afternoon break]*. *[Name of child]* will be given/supervised whilst he/she takes their medication by *[name of member of staff]*. This arrangement will continue until *[either end date of course of medicine or until instructed by parents]*.

Date: _____

Signed: (The Headteacher/Named Member of Staff) _____



Request for pupil to carry his/her medication

Example form for parents to complete if they wish their child to carry his/her own medication

This form must be completed by parents/guardian

Pupil's Name _____ class/form: _____

Address: _____

Condition or illness: _____

Name of Medicine: _____

Procedures to be taken in an Emergency: _____

CONTACT INFORMATION

Name: _____

Daytime Phone No: _____

Relationship to child: _____

I would like my son/daughter to keep his/her medication on him/her for use as necessary.

Signed: _____ Date: _____

Relationship to child: _____