Student HealthCare Plan

Student Details			
Child's Name:			
Year Group/Class/Form:			
Date Of Birth:			
Child's Address:			
Medical Diagnosis Or Condition:			
Date:			
Review Date:			
Family Contact Information			
Contact One			
Name:			
Relationship To Child:			
Work Number :		Home Number:	
Mobile Number:			
Contact Two			
Name:			
Relationship To Child:			
Phone Number (Work):			
(Home):			
(Mobile):			
Clinic/Hospital Contact			
Name:		**Phone Number:**	
Address:			
Child's General Practitioner			
Name:		**Phone Number:**	
Address:			
To be completed by the School: Who Is Responsible For Providing Support In School			

Medical Details Please complete details below if applicable
Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues, etc.
Please provide the name of medication, dose, method of administration, when it should be taken, side effects, contra-indications, administered by/self-administered with/without supervision:
Does your child have any daily care requirements:
Does your child need any specific support for their educational, social and emotional needs:
Are there any arrangements that need to be made for school visits/trips:
Other relevant information:
Please describe what constitutes an emergency, and the action to take if this occurs:

To be Completed by the School
Responsible person in an emergency (state if different for off-site activities):
This Plan has been developed with:
Is Staff training needed/undertaken: please specify who, what and when:
To be Completed by the School: Form copied to:

Parental Agreement for the School to Administer Medicine

The school will not give your child medicine unless you complete and sign this form.

Administration of Medication Form				
To be Completed by the School: Date for review to be initiated by:				
Name of child:				
Date of birth:				
Group/class/form:				
Medical condition or illness:				
Medicine				
Name/type of medicine *(as described on the container):*				
Expiry date:				
Dosage and method:				
Timing of medication:				
Special precautions/other instructions:				
Any side effects that the school needs to know about:				
Can the Medication Be self-administered?	**Yes**		**No**	
Procedures to take in an emergency:				
NB: All Medicines Must Be In The Original Container As Dispensed By The Pharmacy				
Contact details				
Name:				
Daytime telephone number:		**Address:**		
Relationship to child:				
I understand that I must deliver the medicine personally to:	**Mrs Sally Gladman (Office Supervisor)**			
The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication, or if the medicine is stopped.				
Signature:		**Date:**		
Name:				