Individual Healthcare Plan – FOR MEDICAL CONDITIONS ONLY

Is a meeting with the Pastoral team required to discuss medical issue further: Yes ☐ No ☐

Child's name	
Form group	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Phone no. (mobile)	
(home)	
(work)	
Name	
Relationship to child	
Phone no. (mobile)	
(home)	
(work)	

Clinic/Hospital Contact

Name	
Phone no.	
G.P. Name	
Phone no.	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the student's educational, social and emotional needs

Arrangements for school visits/trips etc.

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

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For School use:
Who is responsible for providing support in school

First Aid Team / Named member of staff:

Plan developed with

Staff training needed/undertaken

Parental Agreement for School to Administer Medicine

We will not give your child medicine unless you complete and sign this form in accordance with the school's policy on administering medicine.

Date for review to be initiated by	
Name of child	
Date of birth	
Form group	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – Y/N	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to School Reception	

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(s) ______________________

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Date ____________________________