

MEDICATION

PLAN

(LONG TERM MEDICATION – over 1 month)

NAME: ………………………………

FORM 1

*This section to be completed by all*

Selwood Academy

Name of Academy

Child’s name

Group/class/form

Date of Birth

Child’s address

Medical diagnosis/condition or

Reason for medication

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Contact Information

Name

Phone No. (work)

(home)

(mobile)

Name

Phone No. (work)

(home)

(mobile)

*The remainder of Form 2 to be complete if medication required for over 1 month*

Clinic/Hospital Contact –

Name

Phone no.

G.P.

Name

Phone No.

Describe medical needs and give details of child’s symptoms

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

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

Follow up care

Who is responsible in an emergency (*state if different for off-site activities)*

Form copied to

FORM 2

Parental agreement for the Academy to administer medicine

*To be completed in full by all. The Academy will not give your child medicine unless you complete and sign this form.*

Selwood Academy

Name of Academy

Date

Child’s name

Group/class/form

Name and strength of

Medicine

Expiry date

How much to give

(i.e. dose to be given)

When to be given

Any other instructions

Number of tablets/

quantity given to

Academy

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

Daytime phone no. of

Parent or adult contact

Name and phone no. of

GP

Agreed review date of this Health Care Plan to be initiated by Melissa Singer

Spot checks will be made on a regular basis and a review carried out at the end of each term

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Academy staff administering medicine in accordance with the Academy’s policy. I am confident my child can carry their medication to and from school as required and will hand it in to Reception as soon as they arrive. I will inform the Academy immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FORM 3

Academy agreement to administer medicine

*To be completed by the Head Teacher or nominated person*

Selwood Academy

Name of Academy

It is agreed that [*name of child*] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will

receive:

[quantity and name of medicine] As per form 2

Every day at: (*time to be administered eg., lunchtime or afternoon break*) As per form 2

He/she will be given/supervised whilst he/she takes their medication by any two members of the Admin & Finance Team

This arrangement will continue until:

[*either end date of course of medicine or until instructed in writing by parents*]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*The Head Teacher/Named Member of Staff)*