

MEDICATION

PLAN

(LONG TERM MEDICATION – over 1 month)

NAME: ………………………………

FORM 1

Selwood Academy

Name of Academy

Child’s name

Tutor group

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)

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

FORM 2

Parental agreement for the Academy to administer medicine

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

Selwood Academy

Name of Academy

Date

Child’s name

Tutor group

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

End date of medication plan

*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

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 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 the quantity and name of medicine as per form 2

The medicine will be administered at the times as per form 2

He/she will be given/supervised whilst he/she takes their medication by any two members of the Selwood Academy Team

This arrangement will continue until the end date advised as per form 2

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

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*The Head Teacher/Named Member of Staff)*