Date form completed

Date for review

Copies held by

Healthcare Plan

For pupils with medical conditions at school

1. Pupil's information

Name of pupil _____ Class _____

Date of birth _____ ☐ male ☐ female

2. Contact information

Pupil's address _____

_____ Postcode _____

Family contact 1

Name _____

Phone (day) _____

Mobile _____

Phone (evening) _____

Relationship to child _____

Family contact 2

Name _____

Phone (day) _____

Mobile _____

Phone (evening) _____

Relationship to child _____

GP

Name _____

Surgery _____

Phone _____

Specialist contact *(if applicable)*

Name _____

Role _____

Phone _____

Medical condition information

3. Details of pupil's medical conditions

Signs and symptoms of this pupil's condition: _____

_____

_____

_____

Triggers or things that make this pupil's condition/s worse: _____

4. Routine healthcare requirements

(For example, dietary, therapy, nursing needs or before physical activity)

During school hours:

Outside school hours:

5. What to do in an emergency

6. Regular medication taken during school hours

Medication 1

Name/type of medication
(as described on the container):

Dose and method of administration
(the amount taken and how it
is taken, e.g. tablets, inhaler, injection)

When it is taken (time of day)?

Are there any side effects that
could affect this pupil at school?

Medication 2

Name/type of medication
(as described on the container):

Dose and method of administration
(the amount taken and how it
is taken, e.g. tablets, inhaler, injection)

When it is taken (time of day)?

Are there any side effects that
could affect this pupil at school?

Are there are any contraindications
(signs when medication should not be given)?

Are there are any contraindications
(signs when medication should not be given)?

Self-administration: can the pupil administer the medication themselves?

☐ yes ☐ no ☐ yes, with supervision

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☐ yes ☐ no ☐ yes, with supervision

Medication expiry date

Medication expiry date

7. Emergency medication

(please complete even if it is the same as regular medication)

Name/type of medication (as described on the container):

Describe what signs or symptoms indicate an emergency for this pupil

Dose and method of administration (how the medication is taken and the amount)

Are there are any contraindications (signs when medication should not be given)?

Are there any side effects that the school needs to know about?

Self-administration: can the pupil administer the medication themselves?

☐ yes ☐ no ☐ yes, with supervision

Staff members name

Is there any other follow-up care necessary?

Who should be notified?

☐ Parents ☐ Specialist ☐ GP

8. Regular medication taken outside of school hours

(for background information and to inform planning for residential trips)

Name/type of medication (as described on the container):

Are there any side effects that the school needs to know about that could affect school activities?

9. Members of staff trained to administer medications for this pupil

Regular medication

Emergency medication

10. Specialist education arrangements required

(eg activities to be avoided, special educational needs)

11. Any specialist arrangements required for off-site activities

(please note the school will send parents a separate form prior to each residential visit/off-site activity)

12. Any other information relating to the pupil's healthcare in school?

Parental and pupil agreement

I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education (this includes the emergency services).
I give permission for staff to administer my child's regular prescribed medication (or to supervise them if I have advised they are able to administer it themselves).
I understand that I must notify the school immediately of any changes, in writing.

Signed _____ Date _____
Parent/guardian

Print name _____

Permission for emergency medication

- ☐ I agree that my child can be administered their prescribed medication by a member of staff in an emergency
- ☐ I agree that my child can be administered the emergency asthma inhaler in the event that their prescribed medication is unavailable (asthma sufferers only)

Name of medication carried by pupil _____

_____

Signed _____ Date _____
Parent/guardian

Healthcare Professional agreement

☐ I agree that the information given is accurate and up to date.

Signed _____ Date _____

Print Name _____

Job Title

Head teacher agreement

It is agreed that (name of child) _____

- ☐ will receive the above listed medication at the above listed time (see part 6).
- ☐ will receive the above listed medication in an emergency (see part 7).

This arrangement will continue until _____
(either end date of course of medication or until instructed by the pupil's parents)