Date form completed _____

Date for Review _____

Copies held by _____

Healthcare Plan

For pupils with medical conditions at school

Name of Child	In Year
Telephone number of parent to contact in emergency	

Details of pupil's medical conditions

What is/are the medical condition(s)? _____

Signs and symptoms of this pupil's condition: _____

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

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

During school hours _____

Outside school hours

What to do in an emergency

Regular medication taken during school hours

Medication 1	**Medication 2**
Name/type of medication (as described on the container)	Name/type of medication (as described on the container)
Dose and method of administration (the amount taken and how the medication is taken, e.g. tablets, inhaler, injection)	Dose and method of administration (the amount taken and how the medication is taken, e.g. tablets, inhaler, injection)
When it is taken (time of day)?	When it is taken (time of day)?

Are there any side effects that could affect this pupil at school? _____ _____ _____	Are there any side effects that could affect this pupil at school? _____ _____ _____
Are there any contra-indications (signs when this medication should not be given?) _____ _____ _____	Are there any contra-indications (signs when this medication should not be given?) _____ _____ _____
Can the pupil administer the medication themselves? YES / NO (please delete) If NO, supervision should be given by: Staff member's name_____ Medication expiry date_____	Can the pupil administer the medication themselves? YES / NO (please delete) If NO, supervision should be given by: Staff member's name_____ Medication expiry date_____

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 contra-indications (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? *(please tick)*

	Yes		No		yes, with supervision

If supervised, supervised by (staff member):

Is there any other follow-up care necessary?

Who should be notified? *(please tick)*

	Parents
	Specialist
	GP

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?

Members off staff trained to administer medications for this pupil

Regular medication:

Emergency medication:

Specialist education arrangements required
(e.g. activities to be avoided, special educational needs)

Any special arrangements required for off-site activities
(please note the school will send parents a separate form prior to each residential visit/off-site activity)

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/my child's care and education (this includes emergency services). I understand that I must notify the school, in writing, of any changes.

Signed _____ Date _____
Pupil

Print name _____

Signed _____ Date _____
Parent (if pupil is below the age of 16)

Print name _____

Healthcare professional agreement
I agree that the information is accurate and up-to-date

Signed _____ Date _____

Print name _____ Job Title _____

Permission for emergency medication

I agree that the medical information contained in this plan may be shared with individuals involved with my/my child's care and education (this includes emergency services). I understand that I must notify the school, in writing, of any changes.

Please tick below as appropriate

	I agree that I/my child can be administered my/their medication by a member of staff in an emergency
	I agree that my child **cannot** keep their medication with them and that the school will make the necessary medication storage arrangements
	I agree that I/my child **can** keep my/their medication with me/them for use when necessary

Name of medication carried by pupil: _____

Signed _____ Date _____
Parent/guardian for pupil if above age of legal capacity

Headteacher Agreement

It is agreed that (name of child):_____

Please below tick as appropriate

	will receive the above listed medication at the above listed time (see above)
	will receive the above listed medication in an emergency (see above)

This arrangement will continue until: _____

(either end date of course of medication or until instructed by the pupil's parents)