

1. Pupil's information

Name of pupil _____

Form _____ Date of birth _____ Male Female

Member of staff responsible for home – school communication _____

2. Contact information

Pupil's address _____

_____ Postcode _____

Family contact 1

Name _____

Phone (day) _____ Mobile _____

Phone (evening) _____ Relationship with child _____

Family contact 2

Name _____

Phone (day) _____ Mobile _____

Phone (evening) _____ Relationship with child _____

GP

Name _____ Phone _____

Address _____

_____ Postcode _____

Medical Specialist contact

Name _____ Phone _____

Address _____

_____ Postcode _____

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 container):

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?)

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

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

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

Yes No Yes, with supervision by:

Staff member's name

Medication expiry date

Medication 2

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

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?)

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

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

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

Yes No Yes, with supervision by:

Staff member's name

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 medicine is taken and the amount)

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

Are there any side effects that the school should know about?

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

Yes No Yes, with supervision by:

Staff member's name

Is there any 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 medicines for this pupil

Regular medication

Emergency medication

10. Specialist medication arrangements required
(e.g. 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?

Parent and pupil agreement

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

Signed _____ Date _____
 Pupil if over 16

Print name _____

Signed _____ Date _____
 Parent (if pupil under age of 16)

Print name _____

Permission for emergency medication

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 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 (or pupil if above age of legal capacity)

SENCo 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)