Appendix 2: Individual healthcare plan

|  |  |
| --- | --- |
| Name of School |  |
| Students Name |  |
| Tutor Group |  |
| Date of Birth |  |
| Address |  |
| Medical Diagnosis or Condition |  |
| Date |  |
| Review Date |  |

Family contact information

|  |  |
| --- | --- |
| Name |  |
| Relationship to Student |  |
| Phone Number  |  |
| Home  |  |
| Work |  |
| Mobile |  |

|  |  |
| --- | --- |
| Name |  |
| Relationship to Student |  |
| Phone Number  |  |
| Home  |  |
| Work |  |
| Mobile |  |

|  |  |
| --- | --- |
| Name |  |
| Relationship to Student |  |
| Phone Number  |  |
| Home  |  |
| Work |  |
| Mobile |  |

Clinic / hospital contact

|  |  |
| --- | --- |
| Name |  |
| Phone Number |  |

GP contact

|  |  |
| --- | --- |
| Name |  |
| Phone Number |  |

|  |  |
| --- | --- |
| Person who is responsible for providing support in the school  |  |

|  |
| --- |
| Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc. |
| Name of medication, dose, method of administration, when to be taken, side effects, contraindications, administered by/self-administered with/without supervision. |
| Daily care requirements |
| Specific support for the student’s educational, social and emotional needs |
| Arrangements for school visits / trips, etc. |
| Other information |
| Describe what constitutes an emergency, and the action to take if this occurs |
| Who is responsible in an emergency (state if different for off-site activities)  |
| Staff training needed / undertaken – who, what, when |
| Plan developed with |

Appendix 3: Parental / Carer agreement for school to administer medicine

The School will not give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

|  |  |
| --- | --- |
| Name of School |  |
| Students Name |  |
| Tutor Group |  |
| Date of Birth |  |
| Address |  |
| Medical Diagnosis or Condition |  |
| Date |  |
| Review Date |  |

Medicine

|  |  |
| --- | --- |
| Name/type of medicine (as described on container) |  |
| Expiry date |  |
| Dosage and method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school needs to know about? |  |
| Self-administration – Yes/No |  |
| Procedures to take in an emergency |  |

Contact details

|  |  |
| --- | --- |
| Name |  |
| Daytime phone number |  |
| Relationship to child |  |
| Address |  |

I understand that I must deliver the medicine personally to [agreed member of staff]. The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering medicine in accordance with the Trust policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

**Signature(s):**

**Date:**