



HAWRIDGE & CHOLESBURY CHURCH OF ENGLAND SCHOOL

Individual Health Care Plan

Name of school/setting

Hawridge and Cholesbury CE School

Child's name

Class

Date of birth

Child's address

Medical diagnosis or condition

Date

Review date

Family Contact Information

Name

Relationship to child

Phone no. (work)

(home)

(mobile)

Clinic/Hospital Contact (if applicable)

Name

Phone no.

G.P.

Name

Phone no.

Who is responsible for providing support in school



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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, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Impact on education

Specific support for the child's 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*)



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Plan developed with

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Staff training needed/undertaken – who, what, when

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Staff

Name:

Job Title:

Date:

Signed:

Parent

I **give/do not** give permission to the school to display my child's key health information in the medical room. (Please delete as necessary).

Signed (parent/carer):.....

Print name:

Date:



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Parental agreement for school to administer prescribed medicine

This form is to be completed for regular long-term prescribed medication such as an inhaler. If your child has a short-term condition such as an infection, and has been prescribed medication for it, there is a separate form that needs to be completed, which is available from the office.

The school will not give your child regular medicine unless you complete and sign this form. If more than one medicine is required, a separate form should be completed for each one.

Medicine will **only** be given to your child if it is prescribed by your doctor. A qualified member of staff who has undertaken the Administering Medicines course will give medicine to your child.

Name of child

Date of birth

Class

Medical condition or illness

Medicine

Name of medicine
(as described on the container)

Date dispensed

Expiry date

Dosage and method

Timing

Special precautions/other instructions

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

Supervised self-administration (Y/N)

Procedures to take in an emergency

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name

Daytime telephone no.

Relationship to child



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Address

The information given is to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school's policy.

I understand that I must personally deliver the medication to the school office at the beginning of term.

I will collect the medicine from the school when the course is complete and/or at the end of each term to check that it is still in-date.

I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine no longer needs to be administered.

Signature.....

Print name.....

Date.....

For completion by the school

I agree to arrange for the administration of medicines requested by the parent.

Signature.....

Print name.....

Date.....