

**HEALTH CARE PLAN FOR A PUPIL
WITH MEDICAL NEEDS**



| | | | |
|----------------------------------------------------------------------------------------------------------------------|--|---------------------|--|
| Name: | | | |
| Date of Birth: | | | |
| Medical diagnosis or condition | | | |
| Form: | | Review Date: | |
| FAMILY CONTACT INFORMATION | | | |
| Contact 1 | | Contact 2 | |
| Name: | | Name: | |
| Daytime Phone: | | Daytime Phone: | |
| Home Phone: | | Home Phone: | |
| Mobile Phone: | | Mobile Phone: | |
| Email address: | | Email Address: | |
| Relationship: | | Relationship: | |
| Clinic/Hospital contact: | | GP: | |
| Name: | | Name: | |
| | | Address: | |
| Phone: | | Phone: | |
| Describe medical needs/condition and give details of pupil's individual symptoms and any medication required: | | | |
| | | | |
| Describe daily care requirements (e.g. before sport / at lunchtime) | | | |
| | | | |

Describe what constitutes an emergency for the pupil and the action to take if this occurs:

Follow up care/review required:

Who is responsible in an emergency (State if different for offsite activities)

Signed:.....Print name:.....

Date:.....

Consent for use and administration of inhalers and EpiPen in school (only sign if child uses one/both)

I give permission for my daughter/son (delete as applicable) to carry an inhaler in school.

Signed..... Print name.....

Date.....

I give permission for my daughter/son (delete as applicable) to carry an EpiPen in school and for a first aider or member of staff to administer the EpiPen if she / he requires it in an emergency.

Signed..... Print name.....

Date.....

Form copied to:

TEACHING / FIRST AID STAFF

MEDICAL PLANS FOLDER IN STUDENT SERVICES

