Form One (Reference 4 : 1)

**Medication in Schools for Pupils**

Health Care Plan for a Pupil with Medical Needs Date / /

|  |  |
| --- | --- |
| Name of Pupil |  |
| Date of Birth |  |
| Condition |  |
|  |  |
| Class |  |

**Contact Information**

Family contact 1

|  |  |
| --- | --- |
| Name |  |
| Phone No: | (home) |  | (work) |  |
| Relationship |  |

Family contact 2

|  |  |
| --- | --- |
| Name |  |
| Phone No: | (home) |  | (work) |  |
| Relationship |  |

GP

|  |  |
| --- | --- |
| Name |  |
| Phone No. |  |  |

Clinic/Hospital Contact

|  |  |
| --- | --- |
| Name |  |
| Phone No. |  |  |

**Plan prepared by:**

|  |  |
| --- | --- |
| Name |  |
| Designation |  |  Date / / |

**Distribution**

|  |  |  |  |
| --- | --- | --- | --- |
| School Doctor |  | School Nurse |  |
| Parent |  | Other |  |

Form One (2)

**MEDICATION IN SCHOOLS FOR PUPILS**

|  |
| --- |
| Describe condition and give details of pupil’s individual symptoms: |
|  |
|  |
|  |
|  |
| Medication |  |
|  |
| Details of dose |  |
| Method and time of administration |  |
|  |
| Daily care requirements (e.g. before sport, dietary, therapy, nursing needs) |
|  |
|  |
| Action to be taken in an emergency |  |
|  |
| Follow up care |  |
|  |
| Members of staff trained to administer medication for this child*(state if different for off-site activities)* |
|  |
|  |

|  |
| --- |
| **I agree that the medical information contained in this form may be shared with individuals involved with the care and education of** |
|  |
| **Signed** |  |  **Date / /** |
|  | Parent or Guardian (or pupil if above age of legal capacity) |