Supporting Pupils with Medical Conditions Policy

Individual Healthcare Plan

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

Who is responsible for providing support in school/ (Head of House, SENCo, SSA, TA)	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc	
List medications	
Name of medication Method of administration When to be taken Dosage How to administer Who to administer Side effects With / without supervision	
Name of medication Method of administration When to be taken Dosage How to administer Who to administer Side effects With / without supervision	
Daily care requirements	
Diet Timetable Activities Other Requirements Special Educational Needs (please give details)	
Other information	
Arrangements for school visits/trips etc	
Other information	

Describe what constitutes an emergency		
Action to take if this occurs		
Who is responsible in an emergency *(state if different for off-site activities)*	1. 2.	
Plan developed with	1. 2. 3.	
Staff training needed/undertaken – who, what, when		
Name	Date delivered / signed	Review
Parent Signature & Date		
Copies to:		

Parental Agreement to Administer Medicine

This agreement MUST be updated Annually, or when there is a change to ANY aspect of the medication to be administered

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

Date for review to be initiated by	
Name of academy	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the Academy needs to know about?	
Self-administration – y/n	
If Yes does the school agree that the child is competent to self-administer	Yes / No (delete as appropriate)
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	
Address	
I understand that I must deliver the medicine personally to this named member of staff	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to academy staff administering medicine in accordance with the academy policy. I will inform the academy immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent Signature(s) _____ Date_____

Medicine Provision Record

This Record MUST be completed and retained when Medicines are brought in to school

The Academy will not give your child medicine unless you complete and sign this form.

Name of child	
Date of birth	
Name of academy	
Group/class/form	
Medical condition or illness	

Medical Regime Outside of School

Name/type of medicine	
Dosage and method	
Times given	
Date when medication was first prescribed	

Medicine Sign in Process

Name of staff receiving medication	
Role	
Date of receipt	
Name/type of medicine	
Quantity received of each dose type	
Explain where this will be stored in school	
Name of the person who will administer it	

The above information is accurate to the best of our knowledge.

Parent Signature(s) _____ Date_____

Staff Signature(s) _____ Date_____