

**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 medicationMethod of administrationWhen to be takenDosageHow to administerWho to administerSide effectsWith / without supervision |
| Name of medicationMethod of administrationWhen to be takenDosageHow to administerWho to administerSide effectsWith / without supervision |
| Daily care requirements  |
| DietTimetableActivitiesOther RequirementsSpecial 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