Insert Pupil’s Photo

** Chestnut Lane School**

**Pupil Health Care Plan**

**Template A: individual healthcare plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of school | Chestnut Lane School | | | |
| 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. |  | | | |

Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

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Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

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Daily care requirements

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Arrangements for school visits/trips etc

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Other information

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Describe what constitutes an emergency, and the action to take if this occurs

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Staff training needed/undertaken – who, what, when

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# Template B: parental agreement for school to administer medicine

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date |  | | | | |
| Name of school | Chestnut Lane School | | | | |
| Name of child |  | | | | |
| Date of birth |  |  |  | |  |
| Class |  | | | | |
| Medical condition or illness |  | | | | |
| **Medicine** |  | | | | |
| Name/type of medicine  *(as described on the container)* |  | | | | |
| Expiry date |  |  |  | |  |
| Dosage and method |  | | | | |
| Confirm this medicine has been given before |  | | | | |
| When was the last dose given |  | | | | |
| Timing in school |  | | | | |
| Duration of medication |  | | | | |
| Special precautions/other instructions |  | | | | |
| Are there any side effects that the school/setting needs to know about? |  | | | | |
| Self-administration – y/n |  | | | | |
| Procedures to take in an emergency |  | | | | |
| Prescription/Non-prescription  (Delete as appropriate) | Prescription | | | Non-prescription | |
| **NB: Medicines must be in the original container as dispensed by the pharmacy**  **Contact Details** | | | | | |
| Name |  | | | | |
| Daytime telephone no. |  | | | | |
| Relationship to child |  | | | | |
| I understand that I must deliver the medicine personally to | The school office | | | | |

The above information 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.

Prescribed Medication: I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. *(delete as appropriate)*

Signature(s) Date

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**Template C: confirmation of the Headteacher’s agreement to administer medicine**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of child |  | | | |
| Quantity and name of medicine |  | | | |
| Frequency/ time of medicine to be administered |  |  |  |  |

This arrangement will continue as specified in Template B*.*

|  |  |
| --- | --- |
| Date: |  |
| Signed: |  |

Mrs G Rehal, Headteacher

**A COPY OF THIS DOCUMENT WILL BE GIVEN TO THE PARAMEDICS IF EMERGENCY SERVICES ARE CALLED**