

**Health Care Plan**

**Pupil: …………………………………………**

Affix Photo

Name of Pupil:

Date Of Birth:

Medical Conditions:

I confirm that the information contained within this Health Care Plan is correct and accurate at the time of writing and I give consent to the staff of St Michael’s Primary School to administer the listed medicine in accordance with the school policy.

Parent/Carer Signature: Date:

Print Name:

Current Year & Class of Child:

This Health Care Plan will be reviewed each year.

Date of Review:

Parent/Carer Signature: Date:

Print Name:

Current Year & Class of Child:

Date of Review:

Parent/Carer Signature: Date:

Print Name:

Current Year & Class of Child:

Emergency Contact Information

## Primary Family Contact:

Name:

Relationship to Child:

Mobile Phone Number:

Home Phone Number:

Work Phone Number:

## Secondary Family Contact:

Name:

Relationship to Child:

Mobile Phone Number:

Home Phone Number:

Work Phone Number:

## Clinic/Hospital Contact:

Name:

Job Title:

Phone Number:

## GP Contact:

Name of Practice:

Name of GP:

Phone Number:

Medical Condition 1:

Pupil’s Individual Symptoms:

Daily Care Requirements during School Hours:

Medication Required during School Hours:

**Medicines must be prescribed by a healthcare professional and in the original container as dispensed by the pharmacy.**

Medicine Expiry Date:

Dose to be administered:

When to be given:

Does the medicine need to be refrigerated?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side Effects:

Any other instructions:

Symptoms of an Emergency:

Actions to be taken in an Emergency:

Medical Condition 2:

Pupil’s Individual Symptoms:

Daily Care Requirements during School Hours:

Medication Required during School Hours:

**Medicines must be prescribed by a healthcare professional and in the original container as dispensed by the pharmacy.**

Medicine Expiry Date:

Dose to be administered:

When to be given:

Does the medicine need to be refrigerated?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side Effects:

Any other instructions:

Symptoms of an Emergency:

Actions to be taken in an Emergency:

Pupil Record: Details of Medication Given to Pupil

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| Date | Time | Name of Medication | Dose Prescribed | Dose Given to Pupil | Signature | Print Name |
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Pupil Record: Details of Medication Given to Pupil

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| Date | Time | Name of Medication | Dose Prescribed | Dose Given to Pupil | Signature | Print Name |
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Pupil Record: Details of Medication Given to Pupil

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| Date | Time | Name of Medication | Dose Prescribed | Dose Given to Pupil | Signature | Print Name |
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Permission for Use of the Emergency **Inhaler**:

If your child is a diagnosed asthma sufferer and you would like your child to have the option of using the School’s Emergency Inhaler in the event that they do not have their inhaler in school, or it has run out or doesn’t work please complete the permission form below.

Name of Child:

DOB:

Class:

## Primary Family Contact:

Name:

Relationship to Child:

Mobile Phone Number:

Home Phone Number:

Work Phone Number:

I can confirm that my child has been diagnosed with asthma and prescribed an inhaler.

My child has a working, in-date inhaler, clearly labelled with their name, which will be stored in their medical box in their class room.

In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Parent/Carer Signature: Date:

Print Name:

Permission for Use of the Emergency **Epipen**:

If your child is a diagnosed a severe allergy and you would like your child to have the option of using the School’s Emergency epipen in the event that they do not have their epipen in school, or it doesn’t work please complete the permission form below.

Name of Child:

DOB:

Class:

## Primary Family Contact:

Name:

Relationship to Child:

Mobile Phone Number:

Home Phone Number:

Work Phone Number:

I can confirm that my child has been diagnosed with a severe allergy and has been prescribed an epipen.

My child has a working, in-date epipen, clearly labelled with their name, which will be stored in their medical box in their class room.

In the event of my child displaying symptoms of a severe allergy, and if their epipen is not available or is unusable, I consent for my child to receive an emergency epipen held by the school for such emergencies.

Parent/Carer Signature: Date:

Print Name:

|  |  |
| --- | --- |
|  | North Road, Highgate  London N6 4BG  Tel: 020 8340 7441  Email: [admin@stmichaelsn6.com](mailto:admin@stmichaelsn6.com) Headteacher: Geraldine Gallagher |