

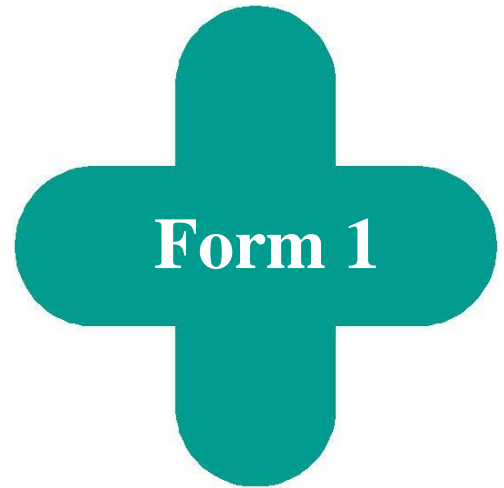
Date form completed \_\_\_\_\_

Date for review \_\_\_\_\_

Copies held by \_\_\_\_\_

# Healthcare Plan

For pupils with medical conditions at school



## 1. Pupil's information

Name of school \_\_\_\_\_

Name of pupil \_\_\_\_\_

Class/form \_\_\_\_\_

Date of birth \_\_\_\_\_  male  female

Member of staff responsible for home-school communication \_\_\_\_\_

## 2. Contact information

Pupil's address \_\_\_\_\_

Postcode \_\_\_\_\_

### Family contact 1

Name \_\_\_\_\_

Phone (day) \_\_\_\_\_

Mobile \_\_\_\_\_

Phone (evening) \_\_\_\_\_

Relationship with child \_\_\_\_\_

### Family contact

2 Name \_\_\_\_\_

Phone (day) \_\_\_\_\_

Mobile \_\_\_\_\_

Phone (evening) \_\_\_\_\_

Relationship with child \_\_\_\_\_

### GP

Name \_\_\_\_\_

Phone \_\_\_\_\_

### Specialist

contact Name \_\_\_\_\_

Phone \_\_\_\_\_

# Medical condition information

## 3. Details of pupil's medical conditions

Signs and symptoms of this pupil's condition:

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Triggers or things that make this pupil's condition/s worse:

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## 4. Routine healthcare requirements

(For example, dietary, therapy, nursing needs or before physical activity)

During school hours:

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Outside school hours:

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## 5. What to do in an emergency

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## 6. Regular medication taken during school hours

### Medication 1

Name/type of medication  
(as described on the container):

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Dose and method of administration  
(the amount taken and how the medication  
is taken, eg tablets, inhaler, injection)

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When it is taken (time of day)?

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Are there any side effects that  
could affect this pupil at school?

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Are there any contraindications  
(signs when this medication should not be given)?

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Self-administration: can the pupil  
administer the medication themselves?

yes  no  yes, with supervision by:

Staff member's name

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Medication expiry date

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### Medication 2

Name/type of medication  
(as described on the container):

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Dose and method of administration  
(the amount taken and how the medication  
is taken, eg tablets, inhaler, injection)

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When it is taken (time of day)?

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Are there any side effects that  
could affect this pupil at school?

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Are there any contraindications  
(signs when medication should not be given)?

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Self-administration: can the pupil  
administer the medication themselves?

yes  no  yes, with supervision by:

Staff member's name

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Medication expiry date

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## 7. Emergency medication

(please complete even if it is the same as regular medication)

Name/type of medication (as described on the container):

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Describe what signs or symptoms indicate an emergency for this pupil

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Dose and method of administration (how the medication is taken and the amount)

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Are there any contraindications (signs when medication should not be given)?

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Are there any side effects that the school needs to know about?

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Self-administration: can the pupil administer the medication themselves?  yes  no  yes, with supervision by:

Staff members name

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Is there any other follow-up care necessary?

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Who should be notified?

Parents  Specialist  GP

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## 8. Regular medication taken outside of school hours

(for background information and to inform planning for residential trips)

Name/type of medication (as described on the container):

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Are there any side effects that the school needs to know about that could affect school activities?

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## 9. Members of staff trained to administer medications for this pupil

Regular medication

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Emergency medication

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## 10. Specialist education arrangements required

(eg activities to be avoided, special educational needs)

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## 11. Any specialist arrangements required for off-site activities

(please note the school will send parents a separate form prior to each residential visit/off-site activity)

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## 12. Any other information relating to the pupil's healthcare in school?

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### Parental and pupil agreement

I agree that the medical information contained in this plan may be shared with individuals involved with my/my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing

Signed \_\_\_\_\_ Date \_\_\_\_\_

Pupil

Print name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Parent (if pupil is below the age of 16)

Print name \_\_\_\_\_

### Healthcare professional agreement

I agree that the information is accurate and up to date.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Job title \_\_\_\_\_

### Permission for emergency medication

I agree that I/my child can be administered my/their medication by a member of staff in an emergency

I agree that my child **cannot** keep their medication with them and the school will make the necessary medication storage arrangements

I agree that I/my child **can** keep my/their medication with me/them for use when necessary

Name of medication carried by pupil \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian (or pupil if above age of legal capacity)

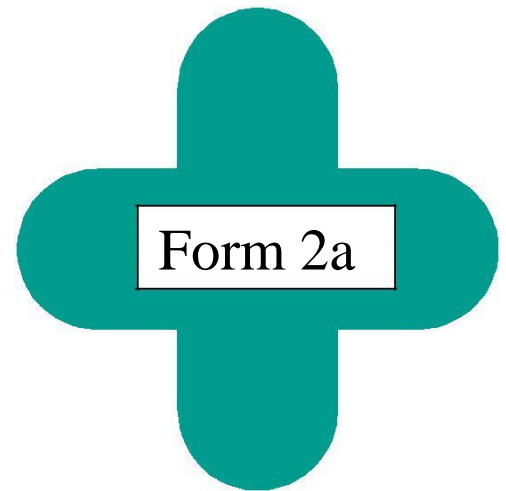
### Principal agreement

It is agreed that (name of child) \_\_\_\_\_

will receive the above listed medication at the above listed time (see part 6).  will receive the above listed medication in an emergency (see part 7).

This arrangement will continue until \_\_\_\_\_  
(either end date of course of medication or until instructed by the pupil's parents).

**PARENTAL AGREEMENT FOR SCHOOL  
TO ADMINISTER ASTHMA MEDICATION**



*The school will not give your child their asthma medication or supervise them taking it themselves unless you complete and sign this form and the school has a policy for staff can administer medication.*

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: **Dartford Primary Academy**      Class: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Contact No. \_\_\_\_\_

**Medication:**

Name/Type of medication: \_\_\_\_\_

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Expiry date: \_\_\_\_\_ Self administration: **YES / NO**

Dose and method: \_\_\_\_\_

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Timing: \_\_\_\_\_

Special precautions: \_\_\_\_\_

Any further information the school needs to know: \_\_\_\_\_

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Procedure to take in an emergency: \_\_\_\_\_

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What constitutes an emergency? \_\_\_\_\_

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**CONTACT DETAILS**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact No. \_\_\_\_\_

Mobile: \_\_\_\_\_

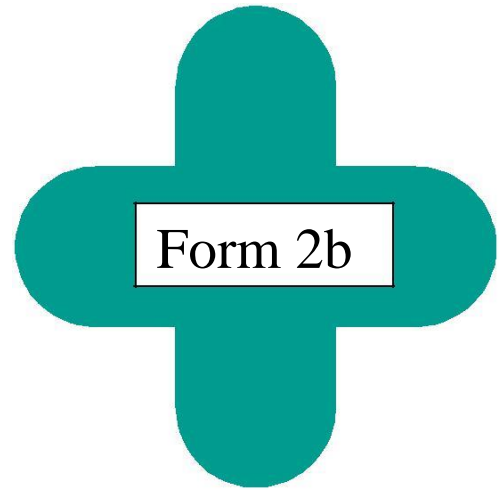
We, the undersigned, consent to this agreement:

<b>Principal/Other (please state):</b>	<b>Parent:</b>
Name: _____	Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

Review date: \_\_\_\_\_



**PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICATION**



*The school will not give your child their medication or supervise them taking it themselves unless you complete and sign this form and the school has a policy for staff can administer medication.*

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: **Dartford Primary Academy** Class: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Contact No. \_\_\_\_\_

**Medication:**

Name/Type of medication: \_\_\_\_\_

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Expiry date: \_\_\_\_\_ Self administration: **YES / NO**

Dose and method: \_\_\_\_\_

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Timing: \_\_\_\_\_

Special precautions: \_\_\_\_\_

Any further information the school needs to know: \_\_\_\_\_

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Procedure to take in an emergency: \_\_\_\_\_

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What constitutes an emergency? \_\_\_\_\_

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**CONTACT DETAILS**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact No. \_\_\_\_\_

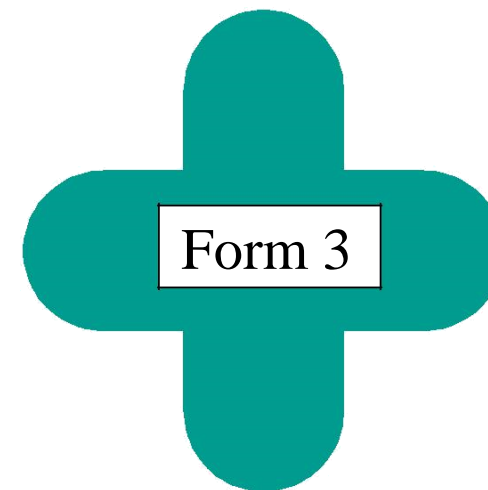
Mobile: \_\_\_\_\_

We, the undersigned, consent to this agreement:

<b>Principal/Other (please state):</b>	<b>Parent:</b>
Name: _____	Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

Review date: \_\_\_\_\_

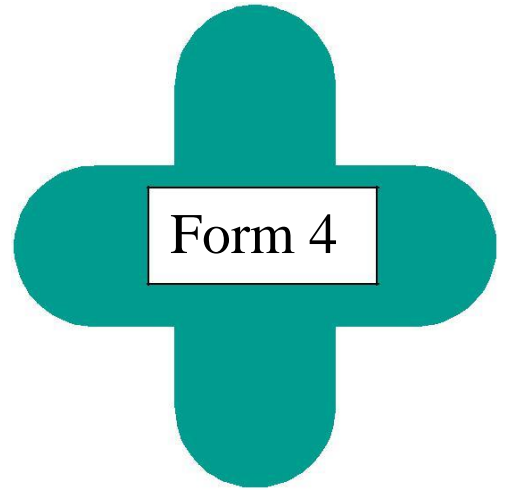
**RECORD OF MEDICATION:**



<b>Date</b>	<b>Pupil's Name</b>	<b>Time</b>	<b>Name of Medication</b>	<b>Dose given</b>	<b>Any reactions</b>	<b>Signature of member of staff</b>	<b>Print Name</b>

# Residential visits and out-of-school activities

For pupils with medical conditions at school



## Contact details

Name \_\_\_\_\_

\_\_\_\_\_

Relationship to pupil \_\_\_\_\_

\_\_\_\_\_

Phone (day) \_\_\_\_\_

\_\_\_\_\_

Mobile \_\_\_\_\_

\_\_\_\_\_

Phone (evening) \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_

The school will not give your child medication unless you complete and sign this form. Please complete this form for medication that your child will need on the visit no earlier than seven days before the start of the visit. For more than two types of medication repeat page f5.2. This form will be attached to the Healthcare Plan and taken on the visit.

Name of school \_\_\_\_\_

\_\_\_\_\_

Date(s) of visit \_\_\_\_\_

Visit destination \_\_\_\_\_

\_\_\_\_\_

Group/class/form \_\_\_\_\_

Name of pupil \_\_\_\_\_

\_\_\_\_\_

Date of birth \_\_\_\_\_

Medical condition/illness \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Medication 1

Name/type of medication  
(as described on the container)

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Expiry date

Dose and method

When is it taken

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Are there any contraindications  
(signs when medication should not be given)

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Are there any side effects that the school/setting  
needs to know about?

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Self-administration  Yes  No  
 Yes with supervision by (staff member below):

What to do in an emergency

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# Medication 2

Name/type of medication  
(as described on the container)

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Expiry date

Dose and method

When is it taken

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Are there any contraindications  
(signs when medication should not be given)

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Are there any side effects that the  
school/setting needs to know about?

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Self-administration  Yes  No  
 Yes with supervision by (staff member below):

What to do in an emergency

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**Please provide any other information that the school needs to be aware of regarding your child's medical condition and recent health before the residential visit or out-of-school activity:**

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Is your child well enough to attend the visit?

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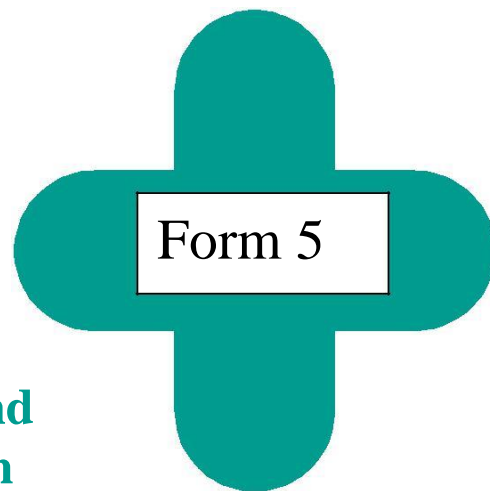
**I understand that I must deliver the medication personally to:**

Agreed member of staff

Signature(s) (parent) Print name

Date

# Contacting Emergency Services



Dial **999**, ask for an ambulance and be ready with the following information

1. Your telephone number.
2. Give your location as follows

**Dartford Primary Academy  
Infants and Nursery  
St Albans Rd  
Dartford DA1 1TE  
Tel 01322 223751**

**Juniors and Star Centre  
York Rd  
Dartford DA1 1SQ  
Tel 01322 224453**

3. State the postcode.
4. Give exact location in the school of the person needing help.
5. Give your name.
6. Give the name of the person needing help.
7. Give a brief description of the person's symptoms (and any known medical condition).
8. Inform ambulance control of the best entrance and state  
that the crew will be met at this entrance and taken to the pupil.
9. Don't hang up until the information has been repeated back to you.

**SPEAK SLOWLY AND CLEARLY**