Individual Health Care Plan

Child's name & Class				
Date of birth				
Child's address				
Medical diagnosis or condition				
Date				
Review date				
1st Contact: Name				
Phone no.				
2nd Contact: Name				
Phone no.				
Clinic/GP/hospital contact				

Describe medical needs and give details of child's symptoms

Daily care requirements *(e.g. before sport/at lunchtime)*

Describe what constitutes an emergency for the child, who is responsible and the action/follow up care to take if emergency occurs

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 policy.
I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent's signature_____ Date _____

Parental agreement for school to administer medicine

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

Name of child				
Date of birth				
Class				
Medical condition or illness				
Name/type of medicine *(as on the container)*				
Date dispensed				
Expiry date				
Agreed review date to be initiated by (name of member of staff)				
Dosage/method/Timing				
Are there any side effects to be aware of? Any special requirements?				
Procedures to take in an emergency				
Name of contact and details				
Parent daytime telephone no.				
Date of GP Annual Review				

- I understand that I must deliver the medicine personally to a member of staff
- The above information is, to the best of my knowledge, accurate at the time of writing
- I give consent to school staff administering medicine in accordance with the school policy.
- 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.
- Asthma: I will provide school with a GP Asthma review annually.
- I am responsible for this medication's expiry and will replace when out of date.

Signature _____ Date_____