**School Health Care Plan for:**

|  |  |
| --- | --- |
| Child’s name |  |
| Date of birth |  |
| Class/form |  |
| Home address |  |
| **Medical Diagnosis/Condition** |  |
| Date condition was diagnosed |  |

**Family Contact Information**

|  |  |
| --- | --- |
| **Parent/Carer name** |  |
| Phone numbers: | Please tick the number that is your preferred contact |
| Home |  |
| Mobile |  |
| Work |  |
| **Second emergency contact:** | |
| **Name & relationship to child** |  |
| Phone numbers: | Please tick the number that is your preferred contact |
| Home |  |
| Mobile |  |
| Work |  |

**GP Details**

|  |  |
| --- | --- |
| Name and Address of GP Practice |  |
| Phone number |  |

**Clinic/Hospital Contact (if applicable)**

|  |  |
| --- | --- |
| Name of consultant |  |
| Phone number |  |

|  |
| --- |
| **Parents/Carers please remember it is your responsibility to:**   * Tell school about any changes in your child’s condition, including medication * Ensure that your child has a reliever medication and spacer in school with them and that it is clearly labelled with their name * Ensure that your child’s medication has not expired |

**Request for a child to carry their own medication**

**To be completed by parent/carer**

|  |  |
| --- | --- |
| Child’s Name |  |
| Class/form |  |
| Home address |  |
| Name of medication and frequency |  |

**Contact Information**

|  |  |
| --- | --- |
| Name |  |
| Daytime phone number |  |
| Relationship to child |  |

Describe how condition/illness affects your child, including their signs, symptoms and triggers

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What are your child’s daily care requirements? Include the name of any medication, dose and how often it is required

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|  |

Describe what an attack looks like for your child and the action to be taken

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|  |

Who is to be contacted in an emergency? Ensure all contact details are shared

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|  |

Copies to:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Signed |  |
| Print Name |  |
| Relationship to Pupil: |  |
| Date Completed: |  |
| Review Date: |  |