Healthcare Plan

Name of School	
Child's Name	
Tutor Group	
Date of Birth	
Child's Address	
Medical Diagnosis or Condition	
Date	
Review date	

CONTACT INFORMATION

Family contact 1		**Family contact 2**	
Name		Name	
Work Phone		Work Phone	
Home Phone		Home Phone	
Mobile		Mobile	

Healthcare Plan

Clinic/Hospital Contact		**GP**	
Name		Name	
Phone No.		Phone No.	
Describe medical needs and give details of child's symptoms			
Daily care requirements (eg before sport/at lunchtime)			
Describe what constitutes an emergency for the child, and the action to take if this occurs			
Follow up care			
Who is responsible in an Emergency (State if different for off-site activities)			
Form copied to			

Healthcare Plan

Request for an Ambulance
Dial 999, ask for ambulance and be ready with the following information
1. Your telephone number
2. Give your location as follows (insert school/setting address)
3. State that the postcode is
4. Give exact location in the school/setting (insert brief description)
5. Give your name
6. Give name of child and a brief description of child's symptoms
7. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to

Healthcare Plan

Request for child to carry his/her medicine

THIS FORM MUST BE COMPLETED BY PARENT/GUARDIAN

If staff have any concerns discuss request with school healthcare professionals

Name of School	
Child's Name	
Group/Class/Form	
Address	
Name of Medicine	
Procedures to be taken in an emergency	

Contact Information

Name	
Daytime Phone No	
Relationship to child	

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signed | Date

If more than one medicine is to be given a separate form should be completed for each type of medicine.

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Administration of Medicines record form (Class 1 and 2 drugs)

Childs Name _____ **Class / form** _____

Name of Medication	Dosage (time, frequency and amount)	Date	Time (24 hour clock)	Signature 1	Signature 2

Healthcare Plan

Staff training record - administration of medicines

Name of School	
Name	
Type of training received	
Date of training completed	
Training provided by	
Profession and title	

I confirm that _____ *[name of member of staff]* has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated (please state how often)

Trainer's signature	
Date	

I confirm that I have received the training detailed above.

Staff signature	
Date	
Suggested Review Date	

Healthcare Plan

Permission letter for administration of medicines

Toot Hill School

To the Parent/Guardian of_____

MEDICINES TO BE GIVEN DURING SCHOOL HOURS

It is very important that medicines that you wish the school to administer are authorised by your General Practitioner, Hospital Consultant or appropriate health professional. Without their signature, authorised staff cannot give any type of medicine to the students in school.

Would you kindly ask your Doctor/Consultant to complete the attached form and return it with the medicines prescribed to the nominated responsible person in the school. You will need to have a new form completed if the type and dosage of medicine is changed. The medicines MUST be also provided in their original packaging (not broken down and placed in envelopes).

Please remember that any prescribed medicine that is administered by the school **MUST** be removed from the school premises on the last day of the summer term by the parent/guardian in arrangement with a competent member of staff.

These forms are available from the school.

Thank you

Yours sincerely

Healthcare Plan

Medical permission form – GP

Name of Student _____

Address of Student _____

_____

Date of Birth _____

GP _____

GP Tel number _____

LIST OF PRESCRIBED MEDICINES

Name of Medication and strength	Dosage	Frequency	Duration	Date to Commence

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Any other instructions_____

_____

_____

_____

_____

Doctor/Consultant Signature_____

Prescribers Stamp