



# Birches Primary School

## Healthcare Plan for a Pupil with On-going Medical Needs eg: Asthma

**Your child’s medical information will be placed on the school medical information sheet and displayed in designated places in the school.**

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

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

Condition : \_\_\_\_\_

Class : \_\_\_\_\_ Date : \_\_\_\_\_ Review Date : \_\_\_\_\_

### Contact Information

#### Contact 1

#### Contact 2

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

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

Phone No. (work) \_\_\_\_\_

Phone N. (work) \_\_\_\_\_

(home) \_\_\_\_\_

(home) \_\_\_\_\_

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

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

#### G.P. Information

Name : \_\_\_\_\_ Phone No. \_\_\_\_\_

#### Describe condition and give details of pupil’s individual symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

#### Describe what constitutes an emergency for the pupil, and the action to take if this occurs:

\_\_\_\_\_  
\_\_\_\_\_

#### Follow up care:

\_\_\_\_\_  
\_\_\_\_\_



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## Request for school to Administer Medication

The school will not give your child medicine unless you complete and sign this form, and the Principal has agreed that school staff\* can administer the medication.

\*It is at the discretion of staff as to whether or not they agree to administer medication.

### Details of Pupil

Surname : \_\_\_\_\_

Forename(s): \_\_\_\_\_

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

Male/Female : \_\_\_\_\_

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

Class : \_\_\_\_\_

Condition or Illness : \_\_\_\_\_

### Medication

Name/Type of Medication \_\_\_\_\_

(as described on container) :

For how long will your child take this medication: \_\_\_\_\_

Date dispensed \_\_\_\_\_

Full directions for use \_\_\_\_\_

Dosage and Method \_\_\_\_\_

Timing \_\_\_\_\_

Special Precautions \_\_\_\_\_

Side Effects \_\_\_\_\_

Self Administration \_\_\_\_\_

Procedures to take in event of emergency : \_\_\_\_\_

### Contact Details

Name : \_\_\_\_\_ Daytime Tel. No. \_\_\_\_\_

Relationship to Pupil : \_\_\_\_\_ Other contact no. \_\_\_\_\_

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

I understand that I must deliver the medicine personally to class teacher and accept that this is a service which the school is not obliged to undertake.

Signature(s) \_\_\_\_\_ Date : \_\_\_\_\_

Relationship to Pupil \_\_\_\_\_

