Tibshelf Community School

Health Care Plan

Childs Name	
Date of Birth	
Form Group	
Childs address	
Date completed	
Date to be reviewed	
Medical Diagnosis or Condition	
Family Contact Information –First Contact	
Name	
Relation	
Phone Number – work	
home	
Mobile	
Family Contact Information – Second Contact	
Name	
Relation	
Phone Number- work	
home	
Mobile	

Tibshelf Community School

Clinic/ Hospital contact	
Name	
Phone Number	
General Practitioner (GP)	
Name	
Phone Number	
Describe medical needs and give details of child's symptoms	
Daily care requirement (e.g. before sport/ at lunchtime)	
Describe what constitutes an emergency for the child, and action to take if this occurs	
Follow up care	
Who is responsible in an emergency (state if different for off-site activities) First Aider on site	Parents signature
Form copies to	Parents/ School Nurse and various sites on school including in the medical box

Tibshelf Community School

TIBSHELF COMMUITY SCHOOL

Parental Consent for Schools/Setting to Administer Medication

Student's Name .....

D.O.B ..... Form .....

Name and Strength of Medication .....

Dosage and Method .....

When to be given .....

Special precautions .....

Any other instructions .....

Number of tablets/quantity given to school .....

Start Date ..... End Date .....

NB. MEDICATION MUST BE IN THE ORIGINAL CONTAINER, AS DISPENSED BY THE PHARMACY WITH CLEAR INSTRUCTIONS ON HOW MUCH TO GIVE.

Are there any side effects that the School/Setting needs to about

.....

Self-administration YES/NO

Procedures to take in an emergency .....

Telephone number of Parent/Carer .....

Name and number of G.P. .....

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the School staff administering the medication 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 medication is stopped.

Parent's/Carer's signature .....Date.....

Print Name .....

If more than one medication is to be given, a separate form should be completed for each.

Tibshelf Community School

Request for Child to carry His/Her Own Medicine

This form must be completed by parents/carers/student over 16 (delete as appropriate)

If staff have any concerns discuss this request with healthcare professionals

Name of School/Setting	Tibshelf Community School
Childs name	
Date of birth	
Form	
Address	
Name of Medicines	
Procedure to be taken in an emergency	
Contact Information	
Name	
Daytime telephone number	
Mobile Number	
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 one.