



## **MEDICAL CARE PLAN**

Only complete if your child has an on-going medical condition requiring regular treatment or medicines to be kept in school.

To cover the Autumn / Spring / Summer / All Year (please delete as applicable)

Child's Name: \_\_\_\_\_

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

Child's Class: \_\_\_\_\_

Description of Medical Condition (e.g. Asthma)

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Symptoms Shown By Child:

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Medication Required: \_\_\_\_\_

Details of Dose: \_\_\_\_\_

Other information which may be helpful, particularly in an emergency:

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- This information is correct at the time of signing
- I undertake to notify the school office of any change in the information given
- I undertake that adequate supplies of up to date medication are available in school.

Signed: \_\_\_\_\_

Printed: \_\_\_\_\_

Date: \_\_\_\_\_