



Individual Healthcare Plan

The school will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Name of Child: _____

Address: _____

Date of Birth: _____ **Year Group:** _____

GP Contact Number: _____ **GP Name:** _____

Medical diagnosis, condition or illness:

Name of Medication: _____

PLEASE NOTE: medicines must be in the original containers as dispensed by the pharmacy.

Dosage and Method: _____

Frequency: _____

Daily care requirements:

Special precautions/ other instructions:

Emergency procedure:

Emergency Contact 1

Name: _____

Relationship to Child: _____ Contact Number: _____

Emergency Contact 2

Name: _____

Relationship to Child: _____ Contact Number: _____

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

I understand that it is my responsibility to ensure that any medication I provide is not beyond its expiry date and will be renewed as required.

Name: _____

Relationship to Child: _____ Contact Number: _____

Signature: _____ Date: _____

For children prescribed inhalers or EpiPens:

In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Signature: _____ Date: _____

In the event of my child displaying symptoms of anaphylaxis, and if their EpiPen is not available or is unusable, I consent for my child to an EpiPen held by the school for such emergencies.

Signature: _____ Date: _____