St. Joseph's Catholic Primary School

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Healthcare Plan for Pupil with Medical Needs

Surname: _____ ***Class:*** _____
Forename: _____ ***Male/Female:*** _____
D.O.B: _____ ***NHS No:*** _____
Address: _____
_____

Condition of illness: _____
_____

Medication:
Name (type) of medication: _____
How long will you child take this medication: _____
Date dispensed: _____

Full directions for use:
Dosage & Method: _____
Timing: _____
Special Precautions: _____
Side effects: _____
Self administration: _____
Procedures to take in an emergency: _____
_____
_____

Contact Details 1
Name: _____
Contact No: _____
Mobile No: _____
Relationship: _____

Contact Details 2
Name: _____
Contact No: _____
Mobile No: _____
Relationship: _____

Hospital Contact
Name: _____
Contact No: _____
GP Name: _____
GP No: _____

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***Date of Plan*: _____ *Review date*: _____**

Description of condition & details of individual symptoms:

_____

_____

_____

_____

_____

Daily Care Requirements:

_____

_____

_____

_____

_____

Describe what action to take in an emergency:

_____

_____

_____

_____

_____

Follow up care:

_____

_____

_____

_____

_____

Details of who to contact in an emergency

Name: _____

Contact No: _____

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Form completed by:

Name: _____ **Relationship to child:** _____

Signature: _____ **Date :** _____