

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

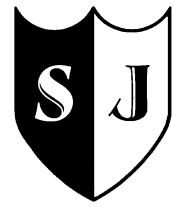
Name: _____
Contact No: _____
Mobile No: _____
Relationship: _____

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:

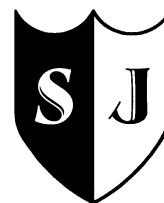
Details of who to contact in an emergency

Name: _____

Contact No: _____

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Form completed by:

Name: _____

Relationship to child: _____

Signature: _____

Date : _____