BOURNVILLE SCHOOL

Individual Healthcare Plan
For pupils with short term medicinal needs at school

1. Pupil's Information:

Name of Pupil: **Date of Birth:** **Member of staff responsible for home school communication:** Mrs E Jones	Photo:

2. Details of pupil's short term medicinal needs

Medical Condition/Health issue/s:
Signs and symptoms of this pupil's condition/s
Triggers or things that make this pupil's conditions worse:

Short term medication:

<u>Medication 1</u> Name/type of medication (as described on the container):

Dose and method of administration (the amount taken and how the medication Is taken, eg tablets, inhaler, injection)

When it is taken (time of day)?

Are there any side effects that could affect this pupil at school?

Are there any contraindications (signs when this medication should not be given)?

Where is the medication to be stored?

Is the medication to stay in school or go home each evening?

Self-administration: can the pupil administer the medication themselves?

Medication expiry date ______________________

Short term medication:

Medication 2 Name/type of medication (as described on the container):

Dose and method of administration (the amount taken and how the medication Is taken, eg tablets, inhaler, injection)

When it is taken (time of day)?

Are there any side effects that could affect this pupil at school?

Are there any contraindications (signs when this medication should not be given)?

Where is the medication to be stored?

Is the medication to stay in school or go home each evening?

Self-administration: can the pupil administer the medication themselves?

Medication expiry date ________________________

Parental and pupil agreement

I agree that the medical information contained in this plan may be shared with individuals involved with my/my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing.

Signed ____________________________ Date___________________________________
Pupil

Print Name ____

Signed ____________________________ Date___________________________________
Parent (if pupil is below the age of 16)

Print Name ____

Healthcare professional agreement

☐ I agree that the information is accurate and up to date.

Signed ______________________________ Date________________________________

Permission for emergency medication

☐ I agree that I/my child can be administered my/their medication by a member of staff in an emergency
☐ I agree that child **cannot** keep their medication with them and the school will make the necessary medication storage arrangements
☐ I agree that I/my child can keep my/their medication with me/them for use when necessary

Name of medication carried by pupil

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Signed ____________________________ Date_________________________________
Parent/guardian for pupil if above age of legal capacity

Head teacher agreement

It is agreed that (name of child)_______________________________________

☐ will receive the above listed medication at the above listed time (see part 6)
☐ will receive the above listed medication in an emergency (see part 7)

This arrangement will continue until
____
(Either end date of course of medication or until instructed by the pupil's parents)