St Albans Girls' School

Learning for Life in a Community where All can Excel

STUDENT SERIOUS MEDICAL CONDITION INDIVIDUAL HEALTHCARE PLAN

(to be completed by Parent/Carer. This form is also available on our website)

Student's name	
Form	
Date of birth	
Name of Diagnosed Medical Illness/Condition	

Parent/Carer Contact Information

Name	
Relationship to student	
Emergency contact number	

MEDICATION : What medication(s) has your daughter/son been prescribed. Please list dose, method of administration, when to be taken, side effects, contra indications, administered by/self-administered with/without supervision *(only to be completed if medication is required to be taken in school)*

ADDITIONAL SUPPORT: Describe any additional support *(other than medication)* your daughter/son requires (e.g. facilities, equipment or devices, environmental issues, physical adaptations etc)

DAILY CARE : Please specify below any daily care requirements, e.g. before sport, at lunchtime, if applicable.

TRIGGERS and SIGNS: What are the triggers, signs & symptoms of the condition?

How is the condition identified & what treatment should be given?

Action to take in an emergency

G.P. Contact

Name	
Address and Telephone Number	

Can the named GP be contacted for information where required (delete as applicable) YES/NO

OTHER INFORMATION

When was your daughter/son diagnosed with this condition?			
Does your daughter/son have disturbed sleep due to his/her condition? *(please tick)*	Rarely	Occasionally	Frequently
How many times, if any, has your daughter/son attended hospital as a result of this condition in the past year?	Not attended	Once or more	State how many times
Who monitors your daughter/son's condition? *(if under a hospital, please give name of hospital and consultant)*			
How often is your daughter/son seen by the hospital/GP/nurse? *(please tick)*	Only when she/he has experienced problems?	On a 3-6 month basis (or more frequent)	Annual Check

SIGNATURE _____**Date**_____
(Parent/Carer)

NAME
(print) _____

FOR OFFICE USE ONLY

Input:_____ Checked: _____

Initial:_____ Date:_____