St Albans Girls' School

Learning for Life in a Community where All can Excel

Individual Healthcare Plan - serious medical condition

(to be completed by parent/carer & healthcare professional)

Student's name	
Form	
Date of birth	
Medical Condition	
Date of diagnosis	
Who monitors your child's condition? Please give contact details of the consultant, hospital and any specialist nurse involved.	

Please briefly explain how the condition affects your child? Are there any particular triggers, signs or symptoms of this condition for your child? Does your child have disturbed sleep due to their condition?

What medication(s) has your child been prescribed for this condition. Please list all medication but only complete the detailed sections below for medication which is required in school.

St Albans Girls' School can only administer your child's medication if you complete this part of the form in full and sign it. All medication must be in the original container/packaging and should ideally have at least 3 months before expiry.

Medication required in school (1)

Name of medicine *(eg paracetamol, ibuprofen)*	
Reason for taking	
Expiry date	
Dose	
Timing	
Special precautions/other instructions	
Are there any side effects that the school needs to know about?	

Medication required in school (2)

Name of medicine *(eg paracetamol, ibuprofen)*	
Reason for taking	
Expiry date	
Dose	
Timing	
Special precautions/other instructions	
Are there any side effects that the school needs to know about?	

This information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine 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 the medicine is stopped. Although staff will endeavour to ensure that medication is administered as requested, the school takes no responsibility for doses missed.

I give/do not give permission for my child to bring home any medication, at the end of the school year or on completion of medication course. We will dispose of uncollected medication

Signature _____ Date _____

(Parent/Carer)

Please describe any additional support (other than medication) (e.g. facilities, equipment or devices, environmental issues, physical adaptations etc) which your child may require.

Name of GP Surgery	
Address and telephone number	
Can we contact GP in an emergency ?	
Is there a specific action to take in an emergency?	

FOR OFFICE USE ONLY
Individual Healthcare Plan

Input:_____ Checked: _____

Initial:_____ Date:_____

Reviewed: