St Albans Girls' School

Learning for Life in a Community where All can Excel

STUDENT ALLERGY INDIVIDUAL HEALTHCARE PLAN (IHP)

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

Student's name	
Form	
Date of birth	

OTHER INFORMATION

When was your child diagnosed with a severe allergy?			
What are your child's allergies? Please list all known allergens			
Is your child's allergy? (please circle)	**Mild**	**Moderate**	**Severe**
Does your child have disturbed sleep due to their asthma? *(please circle)*	Rarely	Occasionally	Frequently
How many times, if any, has your child attended hospital as a result of an allergic reaction in the past year?	Not attended	Once or more	State how many times
Who monitors your child's allergy? *(if under a hospital, please give name of hospital and consultant)*			

G.P. Contact - Can the named GP be contacted for information where required (delete as applicable) YES/NO

Name	
Address and Telephone Number	

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 form in full, and sign it. All medication must be in the original container/packaging and must have at least 3 months before expiry.

Medication required in school (1)

Name of medicine *(eg antibiotic)*	
Reason for taking (*eg throat infection)*	
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 antibiotics)*	
Reason for taking (*eg throat infection)*	
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)

NAME (print) _____

PLEASE NOW COMPLETE THE CONSENT FORM OVERLEAF

FOR OFFICE USE ONLY

Input:_____ Checked: _____

Initial:_____ Date:_____

CONSENT FOR USE OF EMERGENCY ADRENALINE AUTO-INJECTOR AT SCHOOL

For students who have been diagnosed with an allergy and need to carry an Adrenaline Auto Injector (AAI)

Student's name	
Form	
Date of birth	

1. I can confirm that my child has been diagnosed with a severe allergy and has been prescribed an Automated Adrenaline Injector (Epi Pen/Jext)

2. My child will carry their own AAI (Epi Pen/Jext) daily in school.

3. In the event of my child displaying symptoms of an allergic reaction, and if their AAI is not available or is unusable, I consent for my child to receive adrenaline from an emergency AAI held by the school for such emergencies.

Parent/Carer Signature: _____Date:_____

Name (print): _____