INDIVIDUAL HEALTHCARE PLAN

Shire Oak Academy

Name_____

Date of Birth_____

Address

_____

_____

Medical Condition(s)

_____

_____

_____

Contact Information

Name_____

Relationship_____
Telephone_____|_____

Name_____

Relationship_____
Telephone_____

Clinic/Hospital/GP contact (Consultant/Nurse/Specialist/Ward if applicable

Name_____
Telephone_____

GP_____
Telephone_____

Describe medical condition & symptoms

_____
_____

_____
_____

Daily medication requirements

_____
_____
_____
_____

Any other special requirements

_____
_____
_____

What constitutes an emergency?

_____
_____
_____

What action should be taken in an emergency?

_____
_____
_____

Medication, Dose & Time of medication. Does it need to be kept in the fridge?

_____
_____

_____

_____
_____
_____
_____
_____

- ❑ I agree that any medication will be administered to my child by a member of staff

- ❑ I understand that my child **cannot** keep their medication with them during the Academy day (with the exception of inhalers, epi-pens and Diabetes testing equipment) and will be handed in to First Aid at the start of the day for safe keeping.

Signature of Parent/Carer_____
Date_____

Signature of First Aider_____
Date_____