

OFFICE USE ONLY	Date form completed: _____	Date for Review: _____
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FORM A

PLEASE
ATTACH
PHOTO
HERE

HAMILTON COLLEGE PUPIL HEALTHCARE PLAN

Name of Pupil: _____	Address: _____
Date of Birth: _____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
	Postcode: _____
Class/Form Teacher: _____	Class: _____

FAMILY CONTACT 1	
Name: _____	_____
Phone (day): _____	_____
Mobile: _____	_____
Phone (evening): _____	_____
Relationship to child: _____	_____

FAMILY CONTACT 2	
Name: _____	_____
Phone (day): _____	_____
Mobile: _____	_____
Phone (evening): _____	_____
Relationship to child: _____	_____

GP	
Name: _____	_____
Phone: _____	_____

SPECIALIST CONTACT	
Name: _____	_____
Phone: _____	_____

DETAILS OF PUPIL'S MEDICAL CONDITIONS

Medical Condition:

Signs and symptoms of this pupil's condition(s):
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Triggers or things that make this pupil's condition(s) worse:

ROUTINE HEALTHCARE REQUIREMENTS

For example, dietary, therapy, nursing needs or before physical activity

During school hours:

Outside school hours:

What actions may be required in an emergency?

REGULAR/EMERGENCY MEDICATION TO BE TAKEN DURING SCHOOL HOURS

Medication 1

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

REGULAR:

EMERGENCY:

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

REGULAR:

EMERGENCY:

When is it taken (time of day)?

REGULAR:

EMERGENCY:

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

REGULAR:

EMERGENCY:

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

REGULAR:

EMERGENCY:

Medication 2

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

REGULAR:

EMERGENCY:

Dose and method of administration (the amount taken and how the medication is taken, e.g. tablets, inhaler, injection)

REGULAR:

EMERGENCY:

When is it taken (time of day)?

REGULAR:

EMERGENCY:

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

REGULAR:

EMERGENCY:

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

REGULAR:

EMERGENCY:

REGULAR/EMERGENCY MEDICATION TO BE TAKEN DURING SCHOOL HOURS CONTINUED

Self-administration: Can the pupil administer the medication him/herself?

yes no

yes, with supervision by any First Aider.

Self-administration: Can the pupil administer the medication him/herself?

yes no

yes, with supervision by any First Aider.

Medication Expiry Date

REGULAR:

EMERGENCY:

Medication Expiry Date

REGULAR:

EMERGENCY:

Is there any follow up care necessary?

Who should be notified?

Parents Specialist GP

SPECIALIST EDUCATIONAL ARRANGEMENTS REQUIRED: (e.g. activities to be avoided, specific advice or recommendations from Health Professional.

REGULAR MEDICATION TAKEN OUTSIDE OF SCHOOL HOURS (For background information, extra curricular clubs and to inform planning for residential trips)

Name/type of medication (as described on the container);

Are there any side effects that the school needs to know about that could affect school activities?

ANY SPECIAL ARRANGEMENTS REQUIRED FOR OFF-SITE ACTIVITIES (please note the school will send a separate form prior to each residential visit/off-site activity)

ANY ADDITIONAL INFORMATION

HAMILTON COLLEGE PUPIL HEALTHCARE PLAN

Parental and Pupil Agreement

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

Pupil Signature: _____

Date: _____

Print Name: _____

Parental Signature: _____
(Parent if the pupil is below age of 16)

Date: _____

Permission for emergency medication (Please indicate which statement applies to you/your child)

- I agree that I/my child can receive my/his/her medication from a member of staff in an emergency.
- I agree that my child **cannot** keep his/her medication with him/her and the school will make necessary arrangements for storage.
- I agree that I/my child **can** keep my/his/her medication with me/him/her for use when necessary.

Name of medication carried by pupil: _____

Signed: _____
(Parent if the pupil is below age of 16)

Date: _____

Member of Senior Leadership Team - Vice Principal (Junior/Senior School)

I agree that (name of child) _____

- will receive the above listed medication at the above listed time.
- will receive the above listed medication in an emergency.

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

Signature: _____

Designation: _____

Date: _____