# The Marist Catholic Primary School

*With Christ as our guide, we learn, we love, we achieve together.*

***Pupil Healthcare Plan***

Date form completed _____
Date for review _____
Copied to Class Teacher / Parents / Medical Room / Pupil File

## 1. Pupil's information

Name of pupil _____ Class _____ Date of birth _____ M / F

Member of staff responsible for home-school communication _____

**GP Practice:** _____ **Phone No.:** _____
**Specialist:** _____ **Phone No.:** _____

## Medical Condition Information

## 2. Details of pupil's medical conditions

Signs and symptoms of this pupil's condition:

_____

_____

Triggers or things that make this pupil's condition/s worse:

_____

_____

## 4. Routine healthcare requirements

**(For example, dietary, therapy, nursing needs or before physical activity)**

During school hours:

_____

_____

Outside school hours:

_____

## 5. What to do in an emergency

_____

_____

_____

## 6. Regular medication taken during school hours

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

_____

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

_____

When it is taken (time of day)? _____

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

_____

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

_____

Self-administration: can the pupil administer the medication themselves?
Yes / No / Yes, with adult supervision

Medication expiry date: _____

## 7. Emergency medication (please complete even if it is the same as regular medication)

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

_____

Describe what signs or symptoms indicate an emergency for this pupil:

_____

Dose and method of administration (how the medication is taken and the amount):

_____

Are there are any contraindications (signs when medication should not be given)?

_____

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

_____

Self-administration: can the pupil administer the medication themselves?
Yes / No / Yes, with adult supervision

Is there any other follow-up care necessary?

_____

Who should be notified? Parents / Specialist / GP

## 8. Regular medication taken outside of school hours

(for background information 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?

_____

## 9. Members of staff trained to administer medications for this pupil

Regular medication: _____

Emergency medication : _____

## 10. Specialist education arrangements required

(e.g. activities to be avoided, special educational needs)

_____

## 11. Any specialist arrangements required for off-site activities

(please note the school will send parents a separate form prior to each residential visit/off-site activity)

_____

## 12. Any other information relating to the pupil's healthcare in school?

_____

## Parental and pupil agreement

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

Print name _____

Signed _____ Date _____

## Permission for emergency medication

I agree that my child can be administered their medication by a member of staff in an emergency:
**Yes / No**

I agree that my child **cannot** keep their medication with them and the school will make the necessary medication storage arrangements:
**Yes / No**

I agree that my child **can** keep their medication with them for use when necessary:
**Yes / No**

Name of medication carried by pupil _____

Name of medication carried by pupil _____

I hereby authorize school staff to administer the medicines listed on this plan, including a "spare" back-up adrenline autoinjector (AAI) if available, In accordance with Department of Health Guidance on the Use of AAIs in Schools:
**Yes / No**

I hereby authorize school staff to administer the medicines listed on this plan, including a "spare" back-up salbutamol inhaler if available:
**Yes / No**

Signed: _____ Date: _____
Parent/guardian