Form C - Health Care Plan (Managing Medicines)

Name of School/Setting	
Child's Name	
Group/Class/Form	
Date Of Birth	
Address	
Medical Diagnosis or Condition	

Family information/Emergency Contact

Name of Parent/Carer	
Phone No (Home)	
(Work)	
(Mobile)	
Name of Emergency Contact	
Phone No (Home)	
(Work)	
(Mobile)	
Name of Health Contact	
Phone No	
Name of GP	
Phone No	

Who is responsible for providing support in school	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily management of medication (including emergency care e.g. before sport/at lunchtime

Additional advice from relevent health care professionals (e.g. specialist nurse etc)

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

Describe what constitutes an emergency, and the action to take if this occurs

Who is responsible in an emergency *(state if different for off-site activities)*

Plan developed with

Staff training needed/undertaken – who, what, when

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Section 2 - Authorisation for the administration of emergency medication

To be completed where administering of emergency medication may be required

Name of School or Setting	
Child's Name	
Date of Birth	
Home Address	
Name of G.P.	
Name of Hospital Consultant (if applicable)	
Details of administration of medication	

Delete where appropriate
I consent to the use of school emergency blue inhaler in expectional circumstances
I consent to the use of the school emergency AAI/epipen in the event of an emergency

Doctor's Signature: _____ Date: _____
(If applicable)

Parent/carer Signature _____ Date: _____

Section 3 – Individual Epilepsy Plan

To be completed where there is a known history of epilepsy

Name of School or Setting	
Child's Name	
Date of Birth	

Emergency Contact	
Name	
Relationship to child	
Phone No.	

<u>Are there any triggers or warnings prior to a seizure?</u>

<u>Description of usual seizures:</u>

<u>Frequency of seizures – Please specify</u>	

Usual Care during a seizure

- Observe time at start of seizure
- Stay with (name)_____ and reassure them
- Summon help
- Protect head from injury
- Maintained privacy & dignity through removing other students from the area
- Other care

Emergency care/medication:
(please write name of medication and individual action i.e. when to give, when to repeat dose)

The emergency procedure may be repeated, if necessary, 4 hours after first initiated and twice in any 24 hours period.

Post Seizure
Usual behaviour (e.g. disorientated/vomiting/sleepy/aggressive).

Note: Place in recovery position if sleepy