**Elmlea Schools’ Trust**

**PARENTS to provide an UP TO DATE photo of child and attach here**

**FORM 2 Individual Health Care Plan and Administering of Medication**

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| **CHILD’S DETAILS** | | |
| **Child’s name** | | |
| Child’s address including postcode |  | |
| Date of birth |  | |
| Year/Class |  | |
| Medical diagnosis or condition |  | |
| **FAMILY CONTACT INFORMATION** | | |
| **CONTACT 1** Parent/Carer’s name |  | |
| Relationship to child |  | |
| Address including postcode if different to child |  | |
| Telephone numbers | Work  Home  Mobile | |
| **CONTACT 2** Parent/Carer’s name |  | |
| Relationship to child |  | |
| Address including postcode if different to child |  | |
| Telephone numbers | Work  Home  Mobile | |
| **MEDICAL TEAM CONTACT INFORMATION** | | |
| **Clinic/Hospital Contacts** | Name  Address  Number | |
| **GP** | Name  Address  Number | |
| **CARE REQUIREMENTS** | | |
| **Child’s name:** | | |
| Describe any specific medical needs and give details of child’s symptoms, triggers, signs, treatments, equipment or devices, environmental issues etc. | |  |
| Describe specific support needed for the pupil’s educational, social and emotional needs | |  |
| I am providing an up to date Hospital Medical Care Plan/Allergy Action Plan/ Flow Chart/letter from GP/nurse/consultant/Seizure Management Plan with this form. | | YES/NO  Type of plan:  If not providing plan, please explain why: |
| If your child does not need any medication to be held in school please cross out next 2 pages and initial and proceed to declarations page. | | |

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| **MEDICINE ONE to be in original container with label as dispensed by pharmacy plus official information leaflet**  **included, which parents must have read and understood.** **One ‘medicine section’ to be completed for each medication.** | |
| Child’s name |  |
| Name of medicine (number one )  (as described on the container) |  |
| Type of medicine E.g. tablet/capsule/liquid/  Inhaler/auto adrenaline injector etc |  |
| Strength of medicine  (as described on the container) |  |
| Expiry date of medication |  |
| Date first dose ever given. School will not  administer first dose of any medication with the  exception of an auto adrenaline injector |  |
| Dosage and method |  |
| Time(s) to be given |  |
| Special precautions/other instructions/  storage information |  |
| Junior pupil allowed to self-administer | Yes/No (delete as appropriate) |
| Describe what constitutes an emergency for  the pupil and procedures to take in an  emergency |  |
| Any known side effects/other information  may be useful for School to be aware of…. |  |
| AUTO ADRENALINE INJECTOR  My child will keep  their AAI …… | (delete as appropriate)  No AAI so not applicable  or  My child will keep one AAI in the Office & one AAI in classroom  or  My child will keep their AAI x2 in their school bag and bring  to and from school daily. I acknowledge this is my  responsibility to ensure they have correct medication in school  at all times. |
| I give permission for school to use the generic  emergency AAI if their own prescribed AAI  cannot be administered correctly without delay. | Yes/No/Not applicable (delete as appropriate) |
| ANTIHISTAMINE  My child will keep  their antihistamine ……  **NOTE:**  **SCHOOL DOES NOT HOLD SPARE**  **GENERIC ANTIHISTAMINE** | (delete as appropriate)  No antihistamine so not applicable  or  My child will keep one antihistamine in the Office &one  antihistamine in the classroom  or  My child will keep their antihistamine in their school bag and  bring to and from school daily. I acknowledge this is my  responsibility to ensure they have correct medication in school at in school at all times. |
| INHALERS: My child will keep their inhaler in…. | (delete as appropriate)  No inhaler so not applicable  or  Class Cupboard/Class Drawer/School Bag/PE bag |

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| **MEDICINE TWO to be in original container with label as dispensed by pharmacy plus official information leaflet**  **included, which parents must have read and understood.** **One ‘medicine section’ to be completed for each medication.** | |
| Name of child |  |
| Name of medicine (number two)  (as described on the container) |  |
| Type of medicine E.g. tablet/capsule/liquid/  Inhaler/auto adrenaline injector etc |  |
| Strength of medicine  (as described on the container) |  |
| Expiry date of medication |  |
| Date first dose ever given. School will not  administer first dose of any medication with the  exception of an auto adrenaline injector |  |
| Dosage and method |  |
| Time(s) to be given |  |
| Special precautions/other instructions/  storage information |  |
| Pupil allowed to self-administer | Yes/No (delete as appropriate) |
| Describe what constitutes an emergency for  the pupil and procedures to take |  |
| Any known side effects/other information  may be useful for School to be aware of…. |  |
| AUTO ADRENALINE INJECTOR  My child will keep  their AAI …… | (delete as appropriate)  No AAI so not applicable  or  My child will keep one AAI in the Office & one AAI in classroom  or  My child will keep their AAI x2 in their school bag and bring  to and from school daily. I acknowledge this is my  responsibility to ensure they have correct medication in school  at all times. |
| I give permission for school to use the generic  emergency AAI if their own prescribed AAI  cannot be administered correctly without delay. | Yes/No/Not applicable (delete as appropriate) |
| ANTIHISTAMINE  My child will keep  their antihistamine ……  **NOTE:**  **SCHOOL DOES NOT HOLD SPARE**  **GENERIC ANTIHISTAMINE** | (delete as appropriate)  No antihistamine so not applicable  or  My child will keep one antihistamine in the Office &one  antihistamine in the classroom  or  My child will keep their antihistamine in their school bag and  bring to and from school daily. I acknowledge this is my  responsibility to ensure they have correct medication in school at in school at all times. |
| INHALERS: My child will keep their inhaler in…. | (delete as appropriate)  No inhaler so not applicable  or  Class Cupboard/Class Drawer/School Bag/PE bag |

**If a third/fourth medicine is required, please photocopy this page or request another ‘medicine section form’ from the School Office.**

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| **DECLARATIONS** | |
| PARENT/GUARDIAN to read and complete | |
| **CHILD’S NAME:** | |
| It is my parental responsibility to provide my child’s medication/s, listed below, is in its original container with  label as dispensed by pharmacy plus official information leaflet included which I have read and understood to  the best of my ability. Yes/No (delete as appropriate) | |
| I understand that I, or a named adult must deliver the medicine safely to the School Office and arrange  collection and safe disposal. Yes/No (delete as appropriate) | |
| I am responsible for supplying in date medication to school and arranging for new medication to be supplied when it has passed its use by date. Yes/No (delete as appropriate) | |
| I have given the School an up to date, signed/stamped Medical Plan from GP/ Doctor/Hospital/Nurse.  Yes/No (delete as appropriate) | |
| I give permission for this information to be circulated to the appropriate members of staff.  Yes/No (delete as appropriate) | |
| INHALERS: I understand: It is my parental responsibility to ensure my child has their inhaler at school. My child is  aware he/she will inform a member of Staff if it is self-administered. My child’s own inhaler must be taken on  school trips/sporting fixtures etc. A spare generic asthma inhaler is available in the School Office for emergencies, and one is taken on school trips/fixtures to be used in an emergency. Yes/No (delete as appropriate) | |
| AUTO ADRENALINE Injectors: I understand: It is my parental responsibility to ensure my child has two in date  auto adrenaline injectors in school at all times: Both must be taken on school trips/fixtures etc.  Yes/No (delete as appropriate)  Spare generic auto adrenaline injector: I give permission for its use if their own prescribed AAI cannot be  administered correctly without delay. Yes/No (delete as appropriate) | |
| The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to  appropriately trained school staff administering medicine in accordance with the school policy. School will NOT  be giving the first dose (with the exception of an auto adrenaline injector). Yes/No (delete as appropriate) | |
| 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. Yes/No (delete as appropriate) | |
| In the event of any difficulties one of the above contacts can be contacted at all times during the school day on the telephone numbers listed above. Yes/No (delete as appropriate) | |
| I understand the school will contact me before administering some prescribed medications to ascertain when the  last dose was taken. e.g. anti-histamines/ paracetamol/ibuprofen. Yes/No (delete as appropriate) | |
| Name of medication/s given in:  1…………………………………………………………………………………………….…… expiry date: ……………………….  2………………………………………………………………………….……………………… expiry date: ………………..……..  3………………………………………………………………………………………………… expiry date: …………….…………..  4………………………………………………………………………………………………… expiry date: ……………………… | |
| Parent’s signature |  |
| Print name |  |
| Date |  |
| **OFFICE USE ONLY** | |
| **Child’s name:** | |
| The school will contact parents before administering some medications to ascertain when the last dose was taken. e.g. anti-histamines/ paracetamol/ibuprofen | |
| Office Staff will arrange for medication to be taken with the Staff Trip Lead when a child goes off site as per school policy | |
| If child refuses medication or if anything of note occurs during the administration parents will be informed. | |
| Is a Personal Emergency Evacuation Plan (PEEP) needed? | YES/NO  If yes the school will action and inform parents |

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| Date medication received in Office |  |
| Up to date Hospital Medical Care Plan/Allergy Action Plan/ Flow Chart/letter from consultant/Seizure Management Plan attached? | YES/NO |
| Expiry date spreadsheet updated | YES/NO |
| Confirmed that the medicine/container is clearly marked with the name of the medicine, pupils name, dosage of the drug, including method of administration and frequency of administration | YES/NO |
| Special storage requirements noted | YES/NO/NA |
| Is Risk Assessment required | YES/NO |
| Staff training required (in addition to regular training) | YES/NO |
| Forms distributed as necessary eg Class Teacher | YES/NO |
| Signed (Member of Staff)  Name printed  Date |  |