Healthcare Plan

Date form completed: _____ Date for review: _____

Healthcare Plan for a Student with a chronic condition at school

1. Student's Information

Name of School: _____

Name of Student: _____ Class: _____

Date of birth: _____ Age: _____

Siblings in the school: _____

Name: _____ Class: _____

Name: _____ Class: _____

2. Contact Information

Student's address: _____

_____

FAMILY CONTACT 1

Name: _____

Phone (day) Mobile: _____ Phone (evening): _____

Relationship to student: _____

FAMILY CONTACT 2

Name: _____

Phone (day) Mobile: _____ Phone (evening): _____

Relationship to student: _____

CONTACT 3

Name: _____

Phone (day) Mobile: _____ Phone (evening): _____

Relationship to student: _____

GP

Name: _____ Phone: _____

CONSULTANT

Name: _____ Phone: _____

Condition information for: _____

3. Details of the student's conditions

Signs and symptoms of this student's condition: _____

_____

_____

_____

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

_____

_____

_____

4. Routine Healthcare Requirements

During school hours: _____

Outside school hours: _____

5. Regular Medication taken during school hours:

6. Emergency medication-Please fill out full details including dosage:

Please also refer to the Emergency Plan for relevant information:
Asthma on page 31, Diabetes on page 51, Epilepsy on page 73, Anaphylaxis on page 95.

7. Activities - Any special considerations to be aware of?

8. Any other information relating to the student's health care in school?

9. Name of Hospital Nurse for the student

Name: _____

Address: _____

Phone: _____

The school may contact the above named for further information or training.

Parental and student agreement (please tick the correct reply)

I agree _____ I do not 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

Signed by parent: _____

Print name: _____

Date: _____

Permission for emergency medication (please tick correct reply)

In the event of an emergency, I agree _____ I do not agree _____ with my child receiving medication administered by a staff member or providing treatment as set out in the attached Emergency Plan.

Signed by parent:

Print name: _____

Date: _____

Form 3: Emergency Medication Provision School Record

Form 4: Staff Training Record

Administration of Medication

Name of school:

Training provided by:

Type of training received:

Date training completed:

I confirm that the following people have received the training detailed above.

Signature of each person attending the training

1.

2.

3.

4.

5.

Trainer's signature: _____ Date:

Use a separate sheet if more than five people have received training.

I confirm that the people listed above have received this training.

Principal's signature: _____ Date:

_____

Date for update training/retraining:

_____