# St Margaret Mary's Catholic Junior School

## Individual Health Plan

**Form 2**

**For pupils with complex health needs at school**

### Pupil Information

Child's name:_____ Class: _____

DOB:_____ Male / Female

Address: _____

Date form completed:_____ Date for review: _____

### Family Contact 1

Name: _____ Relationship with child: _____

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

Mobile: _____

### Family Contact 2

Name: _____ Relationship with child: _____

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

Mobile: _____

Reviewed by:_____ Date:_____ Changes to Individual Health Care Plan: Y N

Reviewed by:_____ Date:_____ Changes to Individual Health Care Plan: Y N

Reviewed by:_____ Date:_____ Changes to Individual Health Care Plan: Y N

Copies held by:_____

### GP

Name:_____

Phone:_____

### Specialist Contact

Name:_____

Phone:_____

**Medical Information**

**1. Details of pupil's medical conditions**

Medical condition: _____

Signs and symptoms of the pupil's condition:_____

_____

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

_____

**2. Routine healthcare requirements**

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

During school hours:_____

_____

Outside of school hours:_____

_____

**3. What to do in an emergency**

_____

_____

_____

**4. Regular medication taken during school hours**

**Medication 1**

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

_____

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

_____

When is it taken: (time of day) _____

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

_____

Are there any contradictions: (signs when this medication should not be taken) _____

_____

Self-administration: can the pupil administer the medication his / herself?

(Delete as appropriate) Yes No Yes, with supervision by

Staff member's name: _____

Medication expiry date:_____

**Medication 2**

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

_____

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

_____

When is it taken: (time of day) _____

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

_____

Are there any contradictions: (signs when this medication should not be taken) _____

_____

Self-administration: can the pupil administer the medication his / herself?

(Delete as appropriate) Yes No Yes, with supervision by

Staff member's name: _____

Medication expiry date:_____

**5. Emergency Medication**

(please complete even if it is the same as the 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 any side effects that could affect this pupil at school:_____

_____

Are there any contradictions: (signs when this medication should not be taken) _____

_____

Self-administration: can the pupil administer the medication his / herself?

(Delete as appropriate) Yes No Yes, with supervision by

Staff member's name: _____

Is there any follow-up care necessary?:_____

Who should be notified? (delete as appropriate) Parent / Carer Specialist GP

**6. Regular medication taken outside of school hours**

(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:

_____

_____

**7. Members of staff trained to administer medications for this pupil:**

Regular medication: _____

Emergency medication: _____

**8. Specialist education arrangements required:**

(eg. activities to be avoided, special educational needs)

_____

_____

_____

**9. Any specialist arrangements required for off-site activities:**

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

_____

_____

_____

**10. Any other information relating to the pupil's healthcare in school?** _____

_____

_____

_____

_____

_____

_____

_____

## Parent and pupil agreement

I agree that the medical information contained in this plan my 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 :(pupil) _____ Name: _____ Date: _____

Signed: (parent) _____ Name:_____ Date: _____

## Healthcare professional agreement

I agree that the information is accurate and up to date.

Signed:_____ Date:_____

Print name:_____ Job title:_____

## Permission for emergency medication

☐ I agree that my child can be administered their medication by a member of staff in an emergency.

☐ I agree that my child can / cannot keep their medication with them for use when necessary.

Name of medication carried by pupil carried by pupil:_____

Signed: (parent)_____ Date:_____

## Head teacher agreement

It is agreed that (name of child): _____ Class: _____

Will receive the above listed medication at the above listed time (see point 4)

☐ Will receive the above listed medication at the above listed time (see point 5)

☐

This agreement will continue until: _____

(either end date of course of medication or until unstructured by the pupil's parents / carers)