ST CUTHBERT MAYNE SCHOOL
PUPIL WITH A MEDICAL CONDITION - HEALTHCARE PLAN

1. Pupil's Information

NAME		Current Class:
Date of Birth		
Date of Admission to SCM		
Additional Information	☐ I enclose 1 x passport sized photo of my child ☐ I enclose a copy of the GP / hospital action plan	
Medical Condition/Allergies		

2. Emergency Contact Information

Contact 1	Name Phone No Mobile No Relationship to Child
Contact 2	Name Phone No Mobile No Relationship to Child
GP Details	Name Surgery Name Surgery Address Phone No

3. Detail's of Child's Medical Conditions

Signs and symptoms of pupil's condition	

4. What to do in an emergency

5. Regular Medication taken during school hours

Name/Type of medicine (as described on the original box/bottle	
Dose and method of administration (the amount taken and how the medication is taken e.g 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 signs when the medication should not be given?	
Self Administration: can the pupil administer the medication themselves?	Yes: No: Yes: with supervision of an adult (Diabetic)
Medication expiry date	Expiry date …….. I agree to be responsible for ensuring all medicines held at school are in date and will supply school with new medication before this medicines expire.
Any specialist arrangements required for off-site activities	

I agree to notify school in writing of any changes to medical conditions or medications or required dosage as soon as the change happens.

Parent/Guardian Signature: …… Print: ……

Date: ……