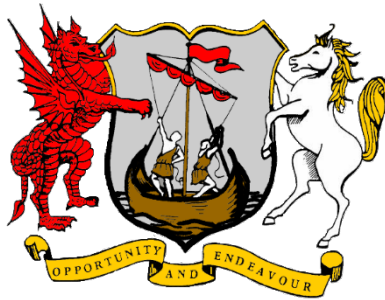


# Haygrove School



## Healthcare Needs Plan

### 1. Student Information

Name: .....

Tutor Group: ..... Date of Birth: ...../...../.....

Address:  
.....  
.....

Postcode: ..... Male  Female

### 2. Emergency Contact Information

First Contact Name: .....

First Contact Home Telephone: .....

First Contact Mobile:..... First Contact Work: .....

First Contact Relationship to Student: .....

Second Contact Name: .....

Second Contact Home Telephone: .....

Second Contact Mobile: ..... Second Contact Work: .....

Second Contact Relationship to Student: .....

Third Contact Name, Contact Number and Relationship to Student:  
.....

Fourth Contact Name, Contact Number and Relationship to Student:  
.....

### 3. GP/Hospital Information

GP Name: ..... Consultant Name: .....

GP Address: ..... Hospital Address: .....

.....

GP Telephone Number: ..... Consultant Telephone Number: .....

.....

#### 4. Medical Condition Information

Please use this box to name any of the student's medical conditions

.....

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.....

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.....

#### 5. Signs and Symptoms of the Student's Conditions

How does each condition affect the student?

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.....

Are there any triggers or situations that can make the condition(s) worse?

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#### 6. What to do in an Emergency

Please detail what constitutes an emergency situation for the student and what action should be taken

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### 7. Routine Healthcare Requirements

Requirements During School Hours (such as Dietary, Therapy, Nursing or Before/After Physical Activity)

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### 8. Routine Healthcare Requirements at Home

Please tell us of any requirements outside of school hours—this will help us to plan for extra-curricular activities, residential trips and inform us of anything that might have an impact on the Student during school hours

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### 9. Regular Medication Taken During School Hours

#### Medication 1

Name of Medication: .....

Dose and Method of Administration: .....

Time(s) to be administered: .....

Any Side Effects? .....

Contraindications (when should the medicine not be given)

.....  
.....

Can the Student Administer their Own Medication? Yes  No

#### Medication 2

Name of Medication: .....

Dose and Method of Administration: .....

Time(s) to be administered: .....

Any Side Effects? .....

Contraindications (when should the medicine not be given)

.....  
.....

Can the Student Administer their Own Medication? Yes  No

### 10. Emergency Medication

Please complete this section even if this is the same as the regular medication

Name of Medication: .....

Dose and Method of Administration: .....

In What Circumstance Should Medication be Administered?

.....

Are There Any Times When Medication Should NOT be Administered?

.....

Any Side Effects? .....

Any Follow Up Care Required following Emergency Administration?

.....

Can the Student Administer their Own Medication? Yes  No

**11. Regular Medication Taken out of School Hours**

Please provide this information in order for us to plan extracurricular activities, residential trips etc.)

Name and Dose of Medication:

.....  
.....

Any Side Effects that Could Affect School Activities?

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.....

**12. Specialist Educational Arrangements Required**

For example, activities to be avoided, things to consider for off site activities

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**13. Any Other Information Relating to the Student’s Healthcare in School**

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### 14. Agreement

I agree that the medical information contained in this plan may be shared with individuals involved with (name) ..... care and education (this includes emergency services). I understand I must notify the school of any changes in writing and a new plan be completed.

Signed ..... Date: ..... / ..... / .....  
Parent/Guardian

Print Name .....

### 15. Permission for Regular and Emergency Medication

- I agree that medication listed in Section 9 may be administered at school
- I agree that in event of emergency, medication listed in Section 10 can be administered in school
- I agree that medication will be provided to the School Principal First Aider, in the original packaging and name and instruction label present.
- I agree that all medication will be stored in the First Aid Room and will not be kept with the student unless absolutely necessary
- I understand that only medication listed in Section 9 and 10 can be routinely administered, and any other medication will require an additional permission slip.

Signed ..... Date: ..... / ..... / .....  
Parent /Guardian

Print Name .....

Office Use Only

Date Form Received: ..... / ..... / .....

Date Added to Arbor: ..... / ..... / .....

Received By: .....

Added By: .....

Job Title: .....

Job Title: .....

Comments/Notes: