Haygrove School

Healthcare Needs Plan

1. Student Information

Name: ……

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

Address:

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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:

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Fourth Contact Name, Contact Number and Relationship to Student:

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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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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)

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……

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?

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Any Side Effects? ……..

Any Follow Up Care Required following Emergency Administration?

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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:

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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: