St Thomas More Catholic Primary School

Pupil Healthcare Plan

Child's name _____

Group/Class/Form _____

Date of Birth _____

Medical Diagnosis or Condition _____

_____

_____

Date _____

Review date _____

Clinic/Hospital contact		**GP**	
Name	_____	Name	_____
Phone No.	_____	Phone No.	_____

Describe medical condition and give details of child's symptoms:

_____

_____

_____

_____

_____

Name of medicine	Expiry date

Daily care requirements: (e.g. dosage; frequency/before sport/at lunchtime)

Describe what constitutes an emergency for the child, and the action to take if this occurs:

- My child is able to administer his/her own medicine. I consent to him/her taking the above dose/s as specified on the prescribed medicine.
- I undertake to keep a record of expiry dates of any medicines and replace when appropriate.
- When necessary I consent to a trained member of staff administering Epipen medication. *(delete if not applicable)*

Signed: ..... Date .....

Form copied to:

Storage of medicine: