BINFIELD CE PRIMARY SCHOOL

LONG TERM CARE PLAN

(HEALTH) CARE PLAN FOR PUPILS IN SCHOOL WITH MEDICAL CONDITIONS

1. Pupil Information

Name of school: _____ Name of pupil: _____

Class: _____ Date of Birth: _____ M or F

Member of staff responsible for
Home-school communication _____

2. Contact Information

Pupil's Address: _____

_____ Post Code: _____

Family Contact 1:

Name: _____

Phone (day): _____ Mobile: _____

Phone (evening): _____ Relationship to Child: _____

Family Contact 2:

Name: _____

Phone (day): _____ Mobile: _____

Phone (evening): _____ Relationship to Child: _____

GP:

Name: _____ Phone: _____

Specialist Contact:

Name: _____ Phone: _____

3. Details of pupil's medical conditions

Signs and symptoms of this pupil's condition:

Triggers/Things that make this pupil's condition/s worse:

4. Routine healthcare requirements

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

During School Hours:

Outside School Hours:

5. What to do in an emergency

6. Regular medication taken during school hours

	Medication 1	**Medication 2**
Name/Type of medication (as described on the container):		
Dose and method of administration (amount to be taken and how the medication is taken, eg: tablets, inhaler, injection):		
When it is to be taken (time of day)?		
Are there any side effects that could affect this pupil at school?		
Are there any contraindications (signs when this medication should not be given)?		
Self Administration: Can the pupil administer the medication themselves? *Please mark appropriately*	Yes No Yes, with supervision by school staff.	Yes No Yes, with supervision by school staff.

7. Emergency medication

(please complete, even if it is the same as 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 contraindications (sings when medication should not be given)?

Are there any side effects the school needs to know about?

Self-administration: can the pupil administer the medication themselves? (*Please mark appropriately)*

Yes No Yes, with supervision by school staff

Is there any other follow-up care necessary?

Who should be notified? (*Please mark appropriately)*

Parents Specialist GP

8. Regular medication taken outside of school hours
(for background information and to inform planning for trips)

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

Are there any side effect that the school needs to know about that could affect school activities?

9. Members of staff trained to administer medications for this pupil (* confirmation provided by healthcare professional)

Regular medication:

Emergency medication:

Cover arrangement if named person absent:

Regular medication:

Emergency medication:

10. Specialist education arrangements required
(eg: activities to be avoided, special educational needs)

11. Any specialist arrangements required for off-site activities
(please note the school will send parent a separate form prior to each residential visit/off-site activity)

12. Any other information relating to the pupil's healthcare in school

Parental and pupil agreement

I agree that the medical information contained in this plan may be shared with individuals involved in my child's care and education (this includes emergency service). I understand that I must notify the school of any changes in writing.

Signed: _____ Date: _____

Print Name: _____

Healthcare Professional Agreement

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

Signed: _____ Date: _____

Print Name: _____ Job Title _____

Permission for emergency medication

(Other than Epipens and Inhalers, which must be carried with the child at all times)

Please tick as appropriate:

	I agree that my child can be administered their medication by a member of staff in an emergency
	I agree that my child **cannot** keep their medication with them in school and the school will make the necessary medication storage arrangements
	I agree that my child **can** keep their medication with them for use when necessary

Name of medication carried by pupil: _____

Signed: _____ Date: _____

For Office Use Only:-

What other considerations does the school need to make?

(For example: Personal care; special toilet arrangements; touch or restraint implications; fire evacuation procedure; pupil's educational, social and emotional needs; how absences will be managed; requirement for extra time to complete exams; use of rest periods; additional support in catching up with lessons, counselling sessions)
Please attach an additional sheet if necessary.

Head Teacher Agreement

It is agreed that (name of child) _____

Will receive the above listed medication on the above listed time (see section 6)
Will receive the above listed medication in an emergency (see section 7)

This arrangement will continue until _____

Signed: _____ Date: _____