FORM 2F

Individual Health Care Plan

Name of Condition:……

This plan relates to the health care needs provided to this school to the child / young person named below in relation to the safe management of the condition above. School staff involved in the day to day care of this child should be made familiar with the contents of this plan so they are aware of when they need to act, and what they and others need to do.

Child_____ **Date of Birth**_____

Class_____

Summary description of medical and health complications associated with this condition:

……
……
……
……
……

Emergency Contact details:

Contact 1

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Contact 2

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Emergency care

Please fill in this section if your child has been prescribed emergency medication for managing this condition.

Child's name_____

Class _____

Name and strength of medication

When should the medication be given?

How much medication should initially be given?

What action should be taken if medication is given?

Non Emergency Care of this pupil's condition

Likely source, cause or early warning signs associated with this condition that would signal to school staff that something requiring medical help might be about to happen?

Any other health conditions to be considered alongside this condition:

Description of how this condition affects this child/young person:

How long do complications/attacks with this condition usually last?

When this condition becomes a problem how long does it usually take to recover?

Medications given at home (please include all medications given)

Name of medicine	Is this prescribed for this condition?	Strength/Amount or dose given	Times given

Medication to given in school

Name of medicine	Is this prescribed for this condition?	Strength/Amount or dose to give	Times to be given

Date Plan Completed

Signed_____ **Name** _____ **Date**_____

Heath care plan agreed by:

Parent/carer: _____ Date_____

Healthcare professional: _____ Date_____

Member of school staff: _____ Date_____

Parents/carers are responsible for ensuring that the school is aware of their child's needs and should update the school as necessary.

This care plan will be reviewed yearly or more often if required, it will be shared with staff in school that are involved in the child's care. Copies will be kept in the school office and in the classroom. Parent/carer to have a copy.

Plan reviewed

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

FORM 3A
Parental Agreement for School/Setting to Administer Medicine (short-term)

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine. You are also agreeing to other appropriate employees of the Local Authority (such as Home-School transport staff) to administer medicine if authorised to do so by the school/setting.

Name of school/setting	
Name of child	
Date of birth	/ /
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine (as described on the container)	
Date dispensed	/ /
Expiry date	/ /
Agreed review date to be initiated by	[name of member of staff]
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school/setting needs to know about?	
Self administration	Yes ☐ No ☐
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff]

I accept that this is a service that the school/setting is not obliged to undertake.
I understand that I must notify the school/setting of any changes in writing.
I understand that a non-medical professional will administer my child's medication, as defined by the prescribing professional only.

Parent/Carer's Signature	

Print Name		Date	

FORM 3B
Parental Agreement for School/Setting to Administer Medicine (long-term)

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine. You are also agreeing to other appropriate employees of the Local Authority (such as Home-School transport staff) to administer medicine if authorised to do so by the school/setting.

Name of school/setting	
Date	/ /
Child's name	
Group/class/form	
Name and strength of medicine	
Expiry date	/ /
How much to give (i.e. dose to be given)	
When to be given	
Any other instructions	
Number of tablets/quantity to be given to school/setting	

Note: Medicines must be in the original container as dispensed by the pharmacy.

Daytime phone no. of parent/carer or adult contact	
Name and phone no. of GP	
Agreed review date to be initiated by	[name of member of staff]

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting and other authorised staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that a non-medical professional will administer my child's medication, as defined by the prescribing professional only.

Parent/Carer's signature			
Print name		**Date**	

If more than one medicine is to be given a separate form should be completed for each one.

FORM 4
Head Teacher/Head of Setting
Agreement to Administer Medicine

Name of school/setting	

It is agreed that [name of child] will receive [quantity and name of medicine] every day at [time medicine to be administered e.g. lunchtime or afternoon break].

[Name of child] will be given/supervised whilst he/she takes their medication by [name of member of staff].

This arrangement will continue until [either end date of course of medicine or until instructed by parent/carers].

Signature			
Print Name		Date	

(The Head teacher/Head of setting/named member of staff)

FORM 5
Record of Medicine Administered to an Individual Child

Name of school/setting	
Name of child	
Date medicine provided by parent/carer	/ /
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	/ /
Quantity returned	
Dose and frequency of medicine	

Staff Signature		Signature of Parent/Carer	

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Form 5 Record of medicine administered to an individual child (Continued)

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

FORM 6
Record of Medicines Administered to all Children

Name of school/setting	

Date	Child's name	Time	Name of Medicine	Dose given	Any Reaction
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					

Signature		Print Name	

FORM 7
Request for Child to Carry His/Her Own Medicine

(This form must be completed by parent/carers/guardian)

If staff have any concerns discuss this request with healthcare professionals.

School/Setting Information

Name of school/setting	
Child's name	
Group/class/form	
Address	
Name of medicine	
Procedures to be taken in an Emergency	

Contact Information

Name	
Daytime phone no.	
Relationship to child	

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signature			
Print Name		**Date**	

If more than one medicine is to be given a separate form should be completed for each one.

FORM 8
Staff Training Record – Administration of Medicines/Medical Support

Name of school/setting	
Name	
Type of training received	
Date of training completed	/ /
Training provided by	
Profession and title	

For Trainer

I confirm that [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [please state how often].

Trainer's signature			
Print Name		**Date**	

For Staff

I confirm that I have received the training detailed above.

Staff signature			
Print Name		**Date**	
Suggested review date			

FORM 9
Authorisation for the Administration of Rectal Diazepam

Name of school/setting	
Child's name	
Date of birth	/ /
Home address	
G.P.	
Hospital consultant	

[name of child] should be given Rectal Diazepam mg. If he/she has

- *a prolonged epileptic seizure lasting over minutes.

OR

- *serial seizures lasting over minutes.

An Ambulance should be called for [name of child]

- *at the beginning of the seizure.

OR

- *if the seizure has not resolved after minutes.

(* please delete as appropriate)

Doctor's signature			
Print Name		**Date**	

Parent/Carer's signature			
Print Name		**Date**	

The following staff have been trained	

Trainers name		Trainers post	

FORM 9 Authorisation for the Administration of Rectal Diazepam (Continued)

NB: Authorisation for the administration of rectal diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- When the diazepam is to be given e.g. after 5 minutes; and
- How much medicine should be given?

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 5 or similar.

FORM 10
Authorisation for the Administration of Buccal Midazolam

Name of school/setting	
Child's name	
Date of birth	/ /
Home address	
G.P.	
Hospital consultant	

[name of child] should be given Buccal Midazolam mg. If he/she has

- *a prolonged epileptic seizure lasting over minutes.

OR

- *serial seizures lasting over minutes.

An Ambulance should be called for [name of child]

- *at the beginning of the seizure.

OR

- *if the seizure has not resolved after minutes.

(* please delete as appropriate)

Doctor's signature			
Print Name		**Date**	

Parent/Carer's signature			
Print Name		**Date**	

The following staff have been trained	

Trainers name		Trainers post	

FORM 10 Authorisation for the Administration of Buccal Midazolam (Continued)

NB: Authorisation for the administration of buccal midazolam

As the indications of when to administer the midazolam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- When the midazolam is to be given e.g. after 5 minutes; and
- How much medicine should be given.

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 5 or similar.

Forms source

http://www.youngsouthampton.org/working-with-children/schools-guidance/health-and-safety/formsset.aspx

FORM 1
Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

1. Your telephone number	
2. Give your location as follows	[insert school setting address]
3. State that the postcode is	
4. Give exact location in the school/setting	[insert brief description]
5. Give your name	
6. Give name of child and a brief description of child's symptoms	
7. Give details of any medicines given or prescribed	
8. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to scene of incident/injured person	

Notes:

1. Speak clearly and slowly and be ready to repeat information if asked
2. Put a completed copy of this form by the telephone.

FORM 2A
Pupil Health Care Plan (General)

(This should be regularly reviewed)

School/Setting Information

Name of school/setting		
Child's name		
Group/class/form		
Date of birth	/ /	
Child's address		
Medical diagnosis or condition		
Date	/ /	
Review date	/ /	

Family Contact Information

Name	
Phone no. (work)	
(home)	
(mobile)	

Name	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P. Information

Name	
Phone no.	

FORM 2A Pupil Health Care Plan (General) (Continued)

Describe medical needs and give details of child's symptoms	
Daily care requirements (e.g. before sport/at lunchtime)	
Describe what constitutes an emergency for the child, and the action to take if this occurs	
Follow up care	
Who is responsible in an emergency (state if different for off-site activities)	
Form copied to	

FORM 2B

Individual Health Care Plan

Allergies / Anaphylaxis

This plan relates to the health care needs provided to this school to the child / young person named below in relation to the safe management of the condition above. School staff involved in the day to day care of this child should be made familiar with the contents of this plan so they are aware of when they need to act, and what they and others need to do.

Child_____ **Date of Birth**_____

Class_____

Any allergic reaction, including the most extreme form, anaphylactic shock, occurs because the body's immune system reacts inappropriately in response to the presence of a substance that it wrongly perceives as a threat.

Anaphylaxis Campaign

Emergency Contact details:

Contact 1

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Contact 2

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Possible symptoms of allergic reactions

A life threatening reaction

Airway	- Tightness or a lump in the throat, hoarse voice, hacking cough.
Breathing	- Short of breath, cough, not able to speak in full sentences, noisy breathing, wheezing.
Conscious level	- Feeling faint, weakness or floppiness, glazed expression, unconscious.
Deterioration	- Symptoms getting steadily worse.

If a child is having a life threatening reaction

1. Give Autoinjector in the outer thigh muscle.
2. Once the Autoinjector has been given, **Dial 999 for the ambulance**. even if the child is making a good recovery
3. If the child is conscious and having breathing difficulties, help them to sit up. If they are faint or floppy, they are better lying flat with their legs raised up.
4. Repeat dose in 5 -10 mins if continued deterioration – often given by the ambulance crew

A non life threatening reaction

Eyes	- itchy, runny, swollen
Nose	- Itchy, runny, congested
Mouth	- itchy or swollen lips or mouth
Skin	- itchy hives or nettle rash, redness, swelling of the face or other parts of the body
Gut	- nausea, stomach cramps, vomiting, diarrhoea

If the child is having a non life-threatening reaction:

1. **Give Antihistamine** syrup or tablet
2. The child should **Rest** and • **Not** do strenuous exercise • **Not** eat a heavy meal. • **Not** have any form of fizzy drink. • **Not** have a hot bath or shower •
3. **Contact** the parents or guardian
4. **Do not leave the child alone** as the severity of symptoms can change quickly

Emergency care

Please fill in this section if your child has been prescribed emergency medication for their allergy.

Child's name_____

Class_____

Name and strength of medication

When should medication be given?

How much medication should initially be given?

What action should be taken if medication is given?

What action should be taken if medication is not effective?

Signed_____ Name _____ Date_____

Non Emergency Allergic Reactions in your child at school

What causes the allergy/ what is your child allergic to?

Any other health conditions:

Early warning signs/Symptoms of child's allergic reaction,

What action should be taken if the child has an allergic reaction?

What can be done to help prevent or minimise allergic reaction?

Medications given at home(please include all medication)

Name of medicine	Is this prescribed for allergy?	Strength/Amount given	Times given

Medication to be given in school

Name of medicine	Is this prescribed for allergy	Strength/Amount given	Times to be given

Heath care plan agreed by:

Parent/carer: _____ Date_____

Healthcare professional: _____ Date_____

Member of school staff: _____ Date_____

Parents/carers are responsible for ensuring that the school is aware of their child's needs and should update the school as necessary.

This care plan will be reviewed yearly or more often if required, it will be shared with staff in school that are involved in the child's care. Copies will be kept in the school office and in the classroom. Parent/carer to have a copy.

Plan reviewed

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

Parents/carers are responsible for ensuring that the school is aware of their child's needs and should update the school as necessary.

This care plan will be reviewed yearly or more often if required, it will be shared with staff in school that are involved in the child's care. Copies will be kept in the school office and in the classroom. Parent/carer to have a copy.

Plan reviewed

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

FORM 2C

Individual Health Care Plan

Asthma

This plan relates to the health care needs provided to this school to the child / young person named below in relation to the safe management of the condition above. School staff involved in the day to day care of this child should be made familiar with the contents of this plan so they are aware of when they need to act, and what they and others need to do.

Child_____ **Date of Birth**_____

Class_____

When a person with asthma comes into contact with something that irritates their airways (an asthma trigger), the muscles around the walls of the airways tighten so that the airways become narrower and the lining of the airways become inflamed and starts to swell making it difficult to breathe.

Asthma UK

Emergency Contact details:

Contact 1

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Contact 2

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Emergency care

Please fill in this section if your child has been prescribed emergency medication for their asthma.

Child's name_____

Class_____

Name and strength of inhaler

When should inhaler be given?

How much medication should initially be given?

What action should be taken if inhaler is given?

What action should be taken if inhaler is not effective?

Signed_____ Name _____ Date_____

Emergency Inhalers

From 1st October 2014 the Human Medicines (Amendment) (No. 2) Regulations 2014 will allow schools to obtain, without a prescription, salbutamol inhalers, if they wish, for use in emergencies. This will be for any pupil with asthma, or who has been prescribed an inhaler as reliever medication. The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty).

The emergency salbutamol inhaler can only be used by children, where parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma or prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.

…… School holds inhalers in school for use in an emergency. Please complete the form below to confirm that you consent to an emergency inhaler being used for your child.

CONSENT FORM: USE OF EMERGENCY SALBUTAMOL INHALER

1. I can confirm that my child has been diagnosed with asthma / has been prescribed an inhaler [delete as appropriate].

2. My child has a working, in-date inhaler, clearly labelled with their name, which will be kept in school for their use

3. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Signed: ……Name(print)…….

Child's name: …… Class: …….

Parent's address and contact detail
……
……
……

Telephone:……

Non Emergency Asthma care for your child - Symptoms of asthma, please describe features of an attack and any early warning signs;

Any other health conditions:

When should inhaler be given?

Are there any triggers for the asthma?

What can be done to help prevent asthma attacks?

Medications given at home(please include all medication)

Name of medicine	Is this prescribed for asthma?	Strength/Amount given	Times given

Medication to given in school

Name of medicine	Is this prescribed for asthma?	Strength/Amount given	Times to be given

Heath care plan agreed by:

Parent/carer: _____ Date_____

Healthcare professional: _____ Date_____

Member of school staff: _____ Date_____

Parents/carers are responsible for ensuring that the school is aware of their child's needs and should update the school as necessary.

This care plan will be reviewed yearly or more often if required, it will be shared with staff in school that are involved in the child's care. Copies will be kept in the school office and in the classroom. Parent/carer to have a copy.

Plan reviewed

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

FORM 2D

Individual Health Care Plan

Diabetes

This plan relates to the health care needs provided to this school to the child / young person named below in relation to the safe management of the condition above. School staff involved in the day to day care of this child should be made familiar with the contents of this plan so they are aware of when they need to act, and what they and others need to do.

Child_____ **Date of Birth**_____

Class_____

Diabetes is a condition where the amount of glucose in the blood is too high because the body cannot use it properly.

This is because the pancreas doesn't produce any insulin, or not enough insulin, to help glucose enter the body's cells – or the insulin that is produced does not work properly (known as insulin resistance).

Diabetes UK

Emergency Contact details:

Contact 1

Name: _____

Relationship: _____

Contact numbers: _____

_____

Contact 2

Name: _____

Relationship: _____

Contact numbers: _____

_____

GP_____ Contact number_____

Specialist Dr/Nurse_____ Contact number_____

Type of diabetes, details of condition

Any other health conditions/ Allergies etc:

Blood glucose monitoring:

Blood glucose target before eating……..

Blood glucose target after eating……..

Monitoring procedure

Insulin administration regime

Medications given at home (please include all medications given)

Name of medicine	Is this prescribed for diabetes?	Strength/Amount given	Times given

Medication to given in school

Name of medicine	Is this prescribed for diabetes?	Strength/Amount given	Times to be given

Emergency care

Please fill in this section to give details of emergency procedures .

Child's name_____

Class _____

Signs of hypoglycaemia (Hypo) - blood sugars too low

Action to be taken if Hypo occurs

Signs of Hyperglycaemia (Hyper) - blood sugars too high

Action to be taken if Hyper occurs

Signed_____ Name _____ Date_____

Suggested Daily Routine, e.g. times to eat, times for blood glucose monitoring etc

Plan for physical Activity

Further information that may be useful to school

Heath care plan agreed by:

Parent/carer_____ Date_____

Healthcare professional_____ Date_____

Member of school staff_____ Date_____

Parents/carers are responsible for ensuring that the school is aware of their child's needs and should update the school as necessary.

This care plan will be reviewed yearly or more often if required, it will be shared with staff in school that are involved in the child's care. Copies will be kept in the school office and in the classroom. Parent/carer to have a copy.

Plan reviewed

By _____ Designation _____ Date_____

By _____ Designation _____ Date_____

By _____ Designation: _____Date_____

FORM 2E

Individual Health Care Plan

Epilepsy

This plan relates to the health care needs provided to this school to the child / young person named below in relation to the safe management of the condition above. School staff involved in the day to day care of this child should be made familiar with the contents of this plan so they are aware of when they need to act, and what they and others need to do.

Child_____ **Date of Birth**_____

Class_____

Having epilepsy means that you have a tendency to have epileptic seizures. A seizure happens when there is a sudden burst of intense electrical activity in the brain, which causes a temporary disruption in the way the brain normally works.

Epilepsy.org.uk

Emergency Contact details:

Contact 1

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Contact 2

Name: _____

Relationship: _____

Contact numbers**:** _____

_____

Condition/cause of epilepsy, anything that makes seizures more likely, early warning signs?

Any other health conditions:

Description of Seizures:

How long do seizures usually last?

What happens after a seizure and how long does it usually take to recover?

Medications given at home (please include all medications given)

Name of medicine	Is this prescribed for epilepsy?	Strength/Amount given	Times given

Medication to given in school

Name of medicine	Is this prescribed for epilepsy?	Strength/Amount given	Times to be given

Emergency care

Please fill in this section if your child has been prescribed emergency medication for their epilepsy.

Child's name_____

Class _____

Name and strength of medication

When should the medication be given?

How much medication should initially be given?

What action should be taken if medication is given?

Date Plan Completed

Signed_____ **Name** _____ **Date**_____

Heath care plan agreed by:

Parent/carer: _____ Date_____

Healthcare professional: _____ Date_____

Member of school staff: _____ Date_____

Parents/carers are responsible for ensuring that the school is aware of their child's needs and should update the school as necessary.

This care plan will be reviewed yearly or more often if required, it will be shared with staff in school that are involved in the child's care. Copies will be kept in the school office and in the classroom. Parent/carer to have a copy.

Plan reviewed

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____

By: _____ Designation: _____ Date: _____