



For students with medical conditions at school

1. Student's Information

Name of student: _____ Date of birth: _____

Tutor Base: _____

Male

Female

2. Contact Information

Student's address: _____

_____ Postcode: _____

Family Contact 1

Name: _____

Phone: _____ Mobile: _____

(day)

Phone: _____ Relationship with Child: _____

(evening)

Family Contact 2

Name: _____

Phone: _____ Mobile: _____

(day)

Phone: _____ Relationship with Child: _____

(evening)

GP

Name: _____ Phone: _____

Specialist contact

Name: _____ Phone: _____

Medical condition information

3. Details of student's medical conditions

Signs and symptoms of this student's condition: _____

Triggers or things that make this student'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

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

Does and method of administration
(the amount taken and how the medication
is taken, eg tablets, inhaler, injection)

When is it taken (time of day)?

Are there any side effects that
could affect this student at school?

Are there any contraindications
(signs when this medication should not be
given)?

Medication 2

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

Dose and method of administration
(the amount taken and how the medication
is taken, eg tablets, inhaler, injection)

When is it taken (time of day)?

Are there any side effects that
could affect this student at school?

Are there any contraindications
(signs when this medication should not be
given)?

7. Emergency medication
(please complete even if it is the same as regular medication)

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

Describe what signs or symptoms indicate an emergency for this student:

Dose and method of administration (how the medication is taken and the amount):

Are there any contraindications (signs when medication should not be given)?

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

**8. Regular medication taken outside of school hours
(background information for emergency services)**

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

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

9. Any other information relating to the student's healthcare in school?

Parental and student agreement

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

Signed: _____ Date: _____

Student:

Print name: _____

Signed: _____ Date: _____

Parent (if pupil is below the age of 16)

Print name: _____

Permission for emergency medication

I agree that I/my child can be administered my/their medication by a member of staff in an emergency.

I agree that my child **cannot** keep their medication with them and the school will make the necessary medication storage arrangements.

Signed: _____ Date: _____

Parent/guardian (or pupil if above age of legal capacity)