# BISHOP PERRIN SCHOOL

HEALTHCARE PLAN FOR A PUPIL WITH MEDICAL NEEDS

*Please complete all sections*

Name _____

Date of Birth _____

Condition _____

_____

_____

Class _____

Name of School _____

_____

Please do not affix photograph, this will be done by school

Date _____

Review Date _____

**CONTACT INFORMATION**

**Home Address** _____

_____

_____

**Family Contact 1**

Name _____

Phone no. (work) _____

(home) _____

Parent/legal guardian with parental responsibility

**Family Contact 2**

Name _____

Phone no. (work) _____

(home) _____

Parent/legal guardian with parental responsibility

**Clinic/Hospital contact**

Name _____

Phone no. (work) _____

**G.P.**

Name _____

Phone no. (work) _____

Describe condition and give details of pupil's individual symptoms:

_____

_____

_____

_____

Daily care requirements: (eg. Before sport/at lunchtime)

_____

_____

_____

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

_____

_____

_____

Child's address:

_____

_____

_____

**Signature of Parent/Legal Guardian with Parental responsibility:**
I give permission for first aid trained staff to administer medication to my child if necessary.

If my child has anaphylaxis and this specified on their care plan, I give permission for the school generic auto injector to be used in emergency situations only.

If my child has asthma and this is specified on their care plan, I give permission for the school generic asthma pump to be used in emergency situations only.

Signature _____

Print Name: _____ Date: _____

I give permission for my child's photograph and name to be displayed in the Medical Room to enable quick identification of my child in emergency situations.

Signature _____

Print Name: _____ Date: _____