



BISHOP PERRIN SCHOOL

HEALTHCARE PLAN FOR A PUPIL WITH MEDICAL NEEDS

Please complete all sections

Name _____

Date of Birth _____

Condition _____

Class _____

Name of School _____

Date _____

Review Date _____

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

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: _____