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.

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: _____