Photo of Student

Wilmslow High School

Student Individual Healthcare Plan

Student's name	Date of birth	Tutor group
Student's address **Post code**		
Medical condition		
Emergency contact numbers		

Name	Relationship to student	Telephone Number

Specialist Healthcare professionals involved	
Name and role	Contact telephone number

1. Describe signs, symptoms and any trigger;

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2. Will your child require any support (including educational, social, emotional) to manage their condition during the school day? YES/NO

If YES, please give details;

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Student Individual Healthcare Plan cont…

Name……..Tutor group……...

3. Will your child require any medication or treatment within the school day? YES/NO

If YES, please give details;

Name of medication	Dose	Time to be taken	Duration of treatment	Additional information *(such as storage information)*

Please delete as appropriate;

- I would like my son/daughter to keep his/her medicine on him/her so that they may self-medicate as necessary.

- I give consent to appropriately trained staff administering medicine in accordance with Wilmslow High School's policy on supporting students with medical conditions. I will inform the medical needs team, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.
- *Please note, any medication to be administered must be in-date, labelled and provided in the original container as dispensed by a pharmacist*

4. Are there any particular instructions in the event of an emergency?
YES/NO
If YES, please give details

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Signed *(parent/carer)*…….....Date……...

Office Use:	Date	Signature
Additional Staff training identified		
Information shared with all teachers		
Information on SIMS/class charts		
Information in Medical Needs Booklet		