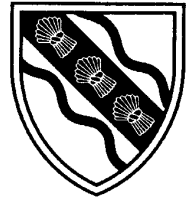


Wilmslow High School

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		