St George's NS

Healthcare Plan/ Administration of Medication Request

Parents' Form: Healthcare Plan/ Administration of Medication Request

Healthcare Plan for a Student with a Chronic Condition at School

Note: To be completed by Parents/Guardians

Date form completed: _____ Date for review: _____

Student's Information

Name of Student: _____ Class Level: _____

Date of Birth: _____ Age: _____

Student's Address: _____

_____

Teacher's Name: _____ Room No: _____

Siblings in the school: _____

Name: _____ Class: _____

Name: _____ Class: _____

Family Contact 1:

Name: _____

Phone (day) Mobile: _____ Phone (evening):_____

Relationship to student: _____

Family Contact 2:

Name: _____

Phone (day) Mobile: _____Phone (evening):_____

Relationship to student: _____

Contact 3:

Name: _____

Phone (day) Mobile: _____ Phone (evening):_____

Relationship to student: _____

GP/Family Doctor:

Name: _____ Phone: _____

Consultant 1:

Name: _____ Phone: _____

Condition information for: _____

Consultant 2 (if applicable):

Name: _____ Phone: _____

Condition information for: _____

3. Details of the student's condition(s)

Signs and symptoms of this student's condition(s):

_____

_____

_____

_____

Triggers or things that make this student's condition(s) worse:

_____

_____

_____

4. Routine Healthcare Requirements

During school hours: _____

_____

_____

_____

_____

_____

Outside school hours: _____

_____

_____

5. **Regular Medication**

_____

_____

_____

_____

_____

[**For School Staff:** Please also refer to the Emergency Plan for the condition attached to this plan]

7. Activities - Any special considerations to be aware of?

_____

_____

8. Any other information relating to the student's health care in school?

_____

_____

_____

The school may contact the person named below for further information or training.

9**. Name of Hospital Nurse for the student**

Name: _____

Address: _____

Phone: _____

Parental agreement (please tick the correct reply)

I agree ☐ or I do not agree ☐ that the medical information contained in this plan may be shared with individuals involved with my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing

Signed by parent: _____

Print name: _____

Date: _____

Permission for emergency medication (please tick correct reply)

In the event of an emergency, I agree ☐ or I do not agree ☐

with my child receiving medication administered by a staff member or providing treatment as set out in the attached Emergency Plan. I understand that the staff /school will not be responsible for any incident/issue that may arise to the administration and/or non-administration of this medication.

Signed by parent: _____

Print name: _____

Date:

Date: _____

The Board of Management has agreed this Healthcare Plan during the meeting held on _____.

_____ _____

Chairperson Date
Board of Management

Emergency Medication Provision School Record

DATE	TIME	STUDENT'S NAME	MEDICATION	DOSE GIVEN	ANY REACTIONS	SIGNATURE OF STAFF MEMBER	PRINT NAME

This form is optional for parents but is recommended for potentially serious/life-threatening conditions

Management of Chronic Medical Conditions - For Staffroom Noticeboard

Child's name: _____ Current Class/Room No: _____

Teacher's name: _____

(Insert photo below)

Details of Child's Medical Condition:

_____

What Staff Should Do in an Emergency Situation:

_____

_____

_____

Parent signature: _____

Date: _____