NAME OF SCHOOL ______________________________ FORM AM1

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS

Date ______________ Review Date ____________

Name of Pupil ____________________________

Date of Birth ____/____/____

Class ________________

National Health Number ______________

Medical Diagnosis ___________________

Contact Information

1 Family contact 1

Name _________________________

Phone No: (home/mobile) _________________________

(work) _________________________

Relationship ______________________________

2 Family contact 2

Name _____________________________

Phone No: (home/mobile) _________________

(work) __________________

Relationship _______________________________

3 GP

Name ____________________________________

Phone No _________________________________

4 Clinic/Hospital Contact

Name _____________________________________

Phone No: ____________________________________

Plan prepared by:

Name _____________________________________

Designation ___________________ Date _________________

Describe condition and give details of pupil's individual symptoms:

____

____

____

Daily care requirements (e.g. before sport, dietary, therapy, nursing needs)

____

____

____

Members of staff trained to administer medication for this child
(state if different for off-site activities)

____

____

Describe what constitutes an emergency for the child, and the action to take if this occurs

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____

____

Follow up care

____

____

____

I agree that the medical information contained in this form may be shared with individuals involved with the care and education of

Signed ____________________ Date ________________
Parent/carer

Distribution

School Doctor ________________ School Nurse ________________

Parent ________________ Other ________________