Coleridge Primary School

Learners for life

RESPECTFUL, RESILIENT, REFLECTIVE, ASPIRING, CARING AND CONSIDERATE

Health Care Plan for a child/pupil with special medical needs

PHOTO

Name______________________________

Address______________________________

____

Date of birth______________________________

Condition______________________________

Contact Information

Contact 1

Name______________________________

Relationship______________________________

Tel: (1) ______________________________

(2)______________________________

(3)______________________________

Contact 2

Name______________________________

Relationship______________________________

Tel: (1)______________________________

(2)______________________________

(3)______________________________

GP/Hospital contact

Name____

Tel____

____

____

Form AOM 3

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Parental consent for school/centre to administer prescribed medication

___

The school will not give your child medicine unless you complete this form, and your GP/Hospital completes form AOM1 A.

Details of Pupil

Name____M/F_____

Address____

____

Date of birth____

Condition/Illness____

Name of medication (as on container)_____________________________________

Date dispensed____

How long will child take this medication___________________________________

Full directions for use

Dosage_______________________________ Timing_________________________

Special precautions____

Side effects____

Self Administration____

Procedures to take in an emergency_____________________________________

____

Contact details

Name____

Address (if different from above)____

Telephone (1)_________________________(2)________________________________

I understand that I must deliver the medicine personally to the school office/classroom and accept that this is a service which the school is not obliged to undertake.

Signature___________________________________ **Date**_____________________

Relationship to pupil____

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Pupil record card

Details of Prescribed medication given to pupil

Name of Pupil ____________________________________

Date of birth____________________________________

Date	Time	Name of Medication	Dose prescribed	Dose given	Administered by signature	

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PUPIL NAME

Describe condition and give details of pupils individual symptons____
____
____
____
____
____
____

Daily care e.g. before sport/at lunch time requirements____
____
____
____
____
____

Action in an emergency____
____
____
____
____
____

Follow up care

____
____
____
____
____
____

Responsibility in an emergency

On site____

Off site____

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____

Medical Practitioners of prescribed medication (Form AOM1A)

To be completed by GP, Doctor, Consultant etc.

Name of child______________________________ **Date of birth**_______________

Address____

____

Type of Medication____

____

Dosage____

Length of time required (please give dates____

____

Any Special requirements/instructions e.g. timing, taken with food etc.

____

____

____

Signed

Date

Official Stamp

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EMERGENCY PLANNING

Request for an ambulance to

COLERIDGE PRIMARY SCHOOL

Dial 999

Ask for an ambulance and be ready with following information

1. **Telephone number** 0208 3403173

2. **Your location as follows :** Coleridge Primary school
   Crouch End Hill,
   N8 8DN (WEST) N8 8DG (EAST)

3. **Give your name and the exact location**

4. **Inform ambulance control the best entrance/access point and state that the crew will be met and taken to __________________**
   (remember to send someone to meet them)

Speak slowly and clearly and repeat information if asked

Form AOM