



*Dream, Believe, Persevere, Achieve*

# MEDICAL FORM 2

## Health Care Plan

Name of school:

Student's name:

Tutor group:

Date of birth:

Student's address:

Medical diagnosis or condition:

Date:

Review date:

### **Family Contact Information**

Name:

Phone no. (Work):

(Home):

(Mobile):

Name:

Phone no. (Work):

(Home):

(Mobile):

### **Clinic/Hospital Contact**

Name:

Phone no:

### **G.P.**

Name:

Phone no:

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Describe medical needs and give details of child's symptoms:

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision:

Daily care requirements (e.g. before sport/at lunchtime):

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

Follow-up care:

Who is responsible in an emergency (state if different for off-site activities):

Form copied to: