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

_____

_____

_____

_____

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 _____