**Child/Young Person Details**

|  |  |
| --- | --- |
| Child’s name: | Click here to enter text. |
| Date of birth: | Click here to enter text. |
| Year group: | Click here to enter text. |
| Address: | Click here to enter text. |
| Medical Condition(s): | Click here to enter text. |
| Date: | Click here to enter text. |
| Date of review: | Click here to enter text. |

**Family Contact Information**

|  |  |
| --- | --- |
| Name: | Click here to enter text. |
| Relationship: | Click here to enter text. |
| Home Phone Number: | Click here to enter text. |
| Mobile Phone Number: | Click here to enter text. |
| Work Phone Number: | Click here to enter text. |
| Email: | Click here to enter text. |

|  |  |
| --- | --- |
| Name: | Click here to enter text. |
| Relationship: | Click here to enter text. |
| Home Phone Number: | Click here to enter text. |
| Mobile Phone Number: | Click here to enter text. |
| Work Phone Number: | Click here to enter text. |
| Email: | Click here to enter text. |

Give a brief description of the medical condition(s) including description of signs, symptoms, triggers, behaviours, facilities, equipment or devices

|  |
| --- |
| Click here to enter text. |

**Routine Monitoring (if applicable)**

|  |  |
| --- | --- |
| What monitoring is required? | Click here to enter text. |
| When does it need to be done? | Click here to enter text. |
| Does it need any equipment? | Click here to enter text. |
| How is it done? | Click here to enter text. |
| Is there a target?If so, what is the target? | Click here to enter text. |

**Medication Required Off-Site:**

|  |
| --- |
| 1. |
| Medication administered off-site: | Click here to enter text. |
| Dosage and method of administration: | Click here to enter text. |
| Timing: | Click here to enter text. |
| Side effects: | Click here to enter text. |

|  |  |
| --- | --- |
| 2. |  |
| Medication administered off-site: | Click here to enter text. |
| Dosage and method of administration: | Click here to enter text. |
| Timing: | Click here to enter text. |
| Side effects: | Click here to enter text. |

**Medication Required Onsite:**

Simon Balle All-through School will not give your child medicine unless you complete and sign the following section. **NB: Medicines must be in their original container as dispensed by the pharmacy.** Simon Balle will email parental contacts 4 weeks prior to the expiration of the medicine held in the main school office and it is your responsibility to replace it. If the medication is not replaced, parental contacts will be sent an expiry alert.

|  |
| --- |
|  |
| Name/ Type of Medication (as described on container): | Click here to enter text. |
| How long will your child take this medication? | Click here to enter text. |
| Dosage and method of administration: | Click here to enter text. |
| Timing if applicable: | Click here to enter text. |
| Side effects:  | Click here to enter text. |
| Self-Administration?Does this need to be supervised? | Click here to enter text. |
| Where will this be stored and how? | Click here to enter text. |

|  |  |
| --- | --- |
|  |  |
| Name/ Type of Medication (as described on container): | Click here to enter text. |
| How long will your child take this medication? | Click here to enter text. |
| Dosage and method of administration: | Click here to enter text. |
| Timing if applicable: | Click here to enter text. |
| Side effects:  | Click here to enter text. |
| Self-Administration, Y/N?Does this need to be supervised? | Click here to enter text. |
| Where will this be stored and how? | Click here to enter text. |

Describe what constitutes an emergency, and the action to take if this occurs? Give details of signs, triggers and follow up actions e.g. rests or tests.

|  |
| --- |
| Click here to enter text. |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Simon Balle All-through School staff administering medicine in accordance with the school policy. I will inform the school, in writing, if there is any changes

I understand that I must deliver the medication personally to the main reception and accept that this is a service which the school is not obliged to undertake.

|  |  |
| --- | --- |
| Parent signature(s) | Click here to enter text. |
| Date: | Click here to enter text. |
| Relationship to pupil | Click here to enter text. |

**Asthma Sufferers Only**

I consent to my child using the school's emergency Salbutamol inhaler, if and when the need arises (for example, when their own is broken, forgotten or empty).

|  |  |
| --- | --- |
| Parent signature(s) | Click here to enter text. |
| Date: | Click here to enter text. |
| Relationship to pupil | Click here to enter text. |

**Impact on Child’s Learning**

|  |  |
| --- | --- |
| How does the child’s medical condition affect learning? I.e memory, processing speed, coordination etc. | Click here to enter text. |
| Does the child require any further assessment of their learning? | Click here to enter text. |
| Does treatment of the medical condition affect behaviour or concentration? If so how? | Click here to enter text. |

**Educational, Social & Emotional Needs**

|  |  |
| --- | --- |
| Is the child/young person likely to need time off because of their condition? | Click here to enter text. |
| What is the process for catching up on missed work caused by absences? | Click here to enter text. |
| Does this child require extra time for keeping up with work? | Click here to enter text. |
| Does this child require any additional support in lessons? If so, what? | Click here to enter text. |
| Is there a situation where the child/young person will need to leave the classroom? | Click here to enter text. |
| Does this child require rest periods? | Click here to enter text. |
| Does this child require emotional support? | Click here to enter text. |
| Does the child have a ‘buddy’ e.g. help carrying bags to and from lessons? | Click here to enter text. |

**School Environments (such as lessons)** *If the lesson is PE please skip this section and fill below*

|  |  |
| --- | --- |
| Can the school environment affect the child’s medical condition?  | Click here to enter text. |
| How does the school environment affect the child’s medical condition? | Click here to enter text. |
| What changes can the school make to deal with these issues? | Click here to enter text. |
| Location of school medical room  | Main School Office  |

**Physical Activity**

|  |  |
| --- | --- |
| Are there any physical restrictions caused by the medical condition(s)? | Click here to enter text. |
| Is any extra care needed for physical activity? | Click here to enter text. |
| Actions before exercise | Click here to enter text. |
| Actions during exercise | Click here to enter text. |
| Actions after exercise | Click here to enter text. |

**Care at Meal Times**

|  |  |
| --- | --- |
| What care is needed? | Click here to enter text. |
| When should this care be provided? | Click here to enter text. |
| How’s it given? | Click here to enter text. |
| Any other special care required? | Click here to enter text. |

**Staff Training**

Governing bodies are responsible for making sure staff have received appropriate training to look after a child/young person. School staff should be released to attend any necessary training sessions if it is agreed they need.

|  |  |
| --- | --- |
| What training is required? | Click here to enter text. |
| Who needs to be trained? | Click here to enter text. |
| Has the training been completed?Please sign and date.  | Click here to enter text. |

Please use this section for any additional information for this child or young person.

|  |
| --- |
| Click here to enter text. |

**Essential Information Concerning This Child/ Young Person’s Health Needs**

|  |  |  |
| --- | --- | --- |
|  | Name | Contact Details |
| Specialist nurse (if applicable):  | Click here to enter text. | Click here to enter text. |
| Consultant paediatrician (if applicable): | Click here to enter text. | Click here to enter text. |
| GP: | Click here to enter text. | Click here to enter text. |
| Head of Year: | Click here to enter text. | Click here to enter text. |
| Clinic/Hospital Contact: | Click here to enter text. | Click here to enter text. |
| SEN Co-ordinator: | Click here to enter text. | Click here to enter text. |
| Other relevant school staff: | Click here to enter text. | Click here to enter text. |
| Person with overall responsibility of implementing plan: | Click here to enter text. | Click here to enter text. |
| Any other provider of alternative provision: | Click here to enter text. | Click here to enter text. |

Plan developed with:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name | Signatures | Date |
| Young Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Parents/ carer | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Healthcare professional  | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| School representative | Click here to enter text. | Click here to enter text. | Click here to enter text. |