St Oscar Romero Catholic School
Medical Conditions and Paracetamol/Ibuprofen Consent

Student's Name:	
Date of Birth:	**Year Group:**
Medical Conditions: Please give more detail for each condition in the Health Care plan. (if your child has no medical conditions please state 'none')	
Is your child Registered Disabled: YES/NO	

ANAPHYLAXIS – PLEASE ALSO COMPLETE HEALTH CARE PLAN

My child will always carry 2 x Adrenalin Auto Injectors (AAI) and their allergy action plan at all times, as required by school. ☐

I will supply 1 x AAI to be held in school as an emergency spare. In the event of an emergency, I give consent for the school to use this medication. ☐

The school's medical office hold 1 x AAI as an emergency spare for all students. In the event of an emergency, I give consent for the school to use this medication. ☐

ASTHMA – PLEASE ALSO COMPLETE HEALTH CARE PLAN

My child will always carry an inhaler, as required by school. ☐

I will supply a spare inhaler to be held in school. In the event of an emergency I give consent, for the school to use this medication. ☐

DIABETES – PLEASE ALSO COMPLETE HEALTH CARE PLAN

My child has Diabetes and will supply emergency medication to be held in school. In the event of an emergency, I give consent for the school to use this medication. ☐

Please update the medical office with any new/changes to medical conditions or circumstances.

Request for school to administer Paracetamol/Ibuprofen

I give permission for_____ (student's name) to have one (500 mg) of Paracetamol at school, when required.

I give permission for_____ (student's name) to have one (200 mg) of Ibuprofen at school, when required.

Only one dose is allowed per day. School will request verbal permission in addition to this written request. I confirm that Paracetamol/Ibuprofen has been administered to him/her previously with no adverse effect. Please inform us of any changes to your consent.

Signed:	**Dated:**
Print name:	**Relationship to student:**

Health Care Plan

Date:			
Child's Name:			
Tutor Group:		**DOB:**	
Child's Address:			
Parent/Carer:			
Phone No, Mobile/Home/Work:			
Medical Conditions:			
Clinic/Hospital Consultant Contact:		**Phone No**.	
GP Surgery:		**Phone No:**	

Describe all medical needs and give as much detail of child's symptoms/treatments where possible. If your child is taking regular medication, please contact the medical office directly.
(Use additional sheets if necessary)

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:

Signature of Parent/Carer: ……...

PRINT NAME: ……Date……