EWELL GROVE PRIMARY AND NURSERY SCHOOL
29 West Street, Ewell, Surrey, KT17 1UZ
020 8393 4393
HEALTH CARE PLAN

Childs Name: ..... Class: …….....

Home Address: .....

Date of Birth: ……...

Parents Name: ……

Parents Home Telephone no:.....

Parents Work / Mobile no: .....

Medical Diagnosis or Condition: .....

Name of GP who prescribed medication: .....

GP Telephone no: .....

Review Date: ……

Who is responsible for providing support in school: ……

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

……

.....

Daily care requirements (eg before sport/at lunchtime):

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……

Specific support for the pupil's educational, social and emotional needs:

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……

Arrangements for school visits / trips etc:

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……

Describe what constitutes an emergency for your child and what action to take should this occur:

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

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……

Plan developed with:

……

……

/cont.

Staff training needed/undertaken – who, what, when

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Follow up care:

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Please confirm in order, who should be contacted in case of an emergency. Please also confirm their contact numbers:

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Please tick the appropriate boxes:

☐ I confirm that the stated medicine has been prescribed by a GP for my child.

☐ My child will be responsible for the self-administration of medicines as directed below.

☐ I agree to members of staff administering medicines/providing treatment to my child as directed below.

Name of Medicine	Dose	Frequency	Expiry Date
Special instructions:			
Allergies or any known possible reactions:			
Other prescribed medicines child takes at home:			

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Ewell Grove staff administering medicine in accordance with the school's policy. I will inform Ewell Grove Primary & Nursery School immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signed: Date: