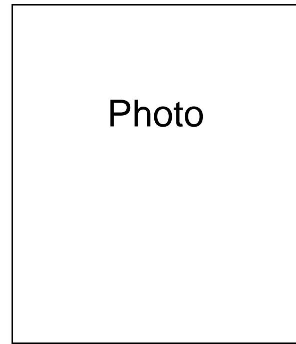
BEACONSFIELD HIGH SCHOOL - HEALTHCARE PLAN

PUPILS WITH MEDICAL NEEDS



Surname: ……………………………………………..

Forenames: …………………………………………..

Date of Birth: …………………………………………

Condition or illness: …………………………………..

……………………………………………………………………………………………

I consent to a member of staff administering ………………………………………….

…………………………………………………………………………………….................
(name of medication as described on the container)

Dosage and method of administration: ……………………………………………….

…………………………………………………………………………………...............

Describe in detail when medication should be administered and any emergency actions (call ambulance, parents etc.):

……………………………………………………………………………………………

…………………………………………………………………………………………….

IT IS THE PARENT'S RESPONSIBILITY TO ENSURE THAT MEDICATION IS IN DATE.

Emergency Contact 1

Name: ……………………………………….

Main Contact No: ………………………..…..

Alternate Contact No: ……………………

Emergency Contact 2

Name: …………………………………………..…

Main Contact No: ………………………………

Alternate Contact No: …………………………

Signed: ……………………………………

Date: …………………