

# Ifield Community College

## Student health Care Plan



Student name	
Date of birth	

This form is to help the school understand the medical needs of your child whilst in school and is used to plan the provision of their care.

My child has no medical conditions

**I agree to inform the school immediately if this changes.**

My child has the following medical condition(s):

A separate form will need to be completed for **Asthma, Epilepsy, Diabetes** and **medication** needed to be taken during school hours.

The school will only accept medication that has been prescribed by a doctor, in its original container as dispensed by the pharmacy and is to include the information leaflet. Medication cannot be given to students without a signed consent form being completed.

**STUDENTS ARE NOT ALLOWED TO CARRY MEDICATION ON THEIR PERSON IN SCHOOL EXCEPT AN INHALER IF AN ASTHMA INFORMATION PLAN HAS BEEN COMPLETED**

**Continued overleaf**

GP details:

GP Name	
Surgery address	
Telephone number	

Parent/ Guardian contact details:

Name	
Daytime telephone number	
Relationship to child	
Address	

The information that I have provided on this form is, to the best of my knowledge, accurate and correct. I agree to inform the school immediately if there is any change in my child's health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional information

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