

MEDICAL CARE PLAN

Please complete the form below, authorising the issue of medication, by a qualified First Aider, to your child, whilst on the school premises.

Child's Surname	Child's Forename	Name of medication	Reason for medication
Date of Birth:			
Name of General Practitioner GP telephone number:	Address of GP		
Dosage:		When to be taken during school day:	
Student's home address and telephone number:			
Any addition information:			

A copy of this Care Plan will be held on record by the First Aid Co-ordinator and discussed **ONLY** with relevant members of staff.

I confirm that I am agreeable for a qualified First Aider at Baines School to issue the above medication to my child as and when specified above.

I agree that my child is responsible for attending the Medical Room when medication is due and I also agree that the School and its First Aiders will not be held responsible for reminding my child when medication is due.

Please complete the information below.

Parent/Carer signature:

PLEASE PRINT YOUR NAME:

Relationship to child:

Date of agreement:

Date of completion of medication: