St Louise de Marillac Primary School
Drumfinn Road, Ballyfermot
Dublin 10

Parents' Form: Healthcare Plan

(To be completed by Parents/Guardians)

Date form completed: _____ Date for review:_____

Healthcare Plan for a Student with a Chronic Condition at School

1. Student's Information

Name of Student:_____ Class Level:_____

Student's Address _____

_____

Teacher's Name: _____ Room No: _____

Date of birth: _____ Age: _____

Siblings in the school: _____

Name: _____ Class:_____

Name: _____ Class:_____

Family Contact 1

Name: _____

Phone (day) Mobile: _____ Phone (evening):_____

Relationship to student: _____

Family Contact 2

Name: _____

Phone (day) Mobile: _____Phone (evening):_____

Relationship to student: _____

Contact 3

Name:_____

Phone (day) Mobile: _____ Phone (evening):_____

Relationship to student: _____

GP/Family Doctor

Name: _____ Phone: _____

Consultant 1

Name: _____ Phone: _____

Condition information for: _____

Consultant 2 (if applicable)

Name: _____ Phone: _____

Condition information for: _____

3. Details of the student's condition/s

Signs and symptoms of this student's condition/s:

_____

_____

_____

_____

Triggers or things that make this student's condition/s worse:

_____

_____

_____

4. **Routine Healthcare Requirements**

During school hours : _____

_____

_____

_____

_____

_____

Outside school hours: _____

_____

_____

5. **Regular Medication taken during school hours: (Please include exact name of medication to be administered/dosage and time/where you suggest it will be stored, etc.)**

Name of medication to be administered:

_____

Exact dosage and time(s):

_____

Recommended storage of medication:

_____

Expiry date on current medication left to the school:

_____

Any other procedure to be followed:

_____

6. **Emergency Medication: (Please include exact name of medication to be administered, including dosage).**

Name and dosage of medication to be administered:

_____

{For School Staff : Please also refer to the Emergency Plan for the condition in the appendices attached to this plan}

7. In-School Activities - Any special considerations to be aware of?

_____

_____

8. Any other information relating to the student's health care in school?

_____

The school may contact the person named below for further information or training.

9. Name of Hospital Nurse for the student

Name: _____

Address: _____

Phone: _____

Parental agreement (please tick)

I agree ☐ that the medical information contained in this plan may be shared with individuals involved with my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing

Signed by parent: _____

Print name: _____

Date: _____

Permission for emergency medication (please tick correct reply)

In the event of an emergency, I agree ☐ or I do not agree ☐

with my child receiving medication administered by a staff member or providing treatment as set out in the school's Emergency Plan for my child's chronic condition. I understand that the staff /school will not be responsible for any incident/issue that may arise to the administration and/or non-administration of this medication.

I agree ☐ that it is my responsibility to ensure that my child's medication in school is within its expiry date at all times.

Signed by parent: _____

Print name: _____

Date:

The Board of Management has agreed this Healthcare Plan during the meeting held on _____.

_____ _____

Chairperson Date

Board of Management

Form 2: **Emergency Medication Provision School Record**

DATE	TIME	STUDENT'S NAME	MEDICATION	DOSE GIVEN	ANY REACTIONS	SIGNATURE OF STAFF MEMBER	PRINT NAME

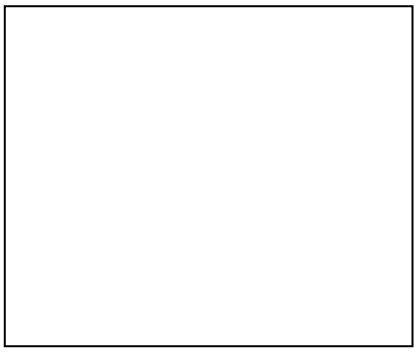
Form 3. This form is optional for parents, but is recommended for potentially serious/life-threatening conditions.

Management of Chronic Medical Conditions. For Staffroom Noticeboard

Child's name: _____ Current Class/Room No: _____

Teacher's name: _____

(Insert photo in box below)



Details of Child's Medical Condition: _____

What Staff Should Do in an Emergency Situation: _____

_____

Parent signature: _____ Date: _____