	# PUPIL CARE PLAN

This form should only be completed if your child has a medical condition

FULL NAME OF PUPIL			
DATE OF BIRTH		YEAR OF ENTRY	
ADDRESS			

MEDICAL DETAILS Please supply as much detail as possible to help us care for your child

MEDICAL CONDITION	
TREATMENT REGIME	
MEDICATION (PRESCRIBED OR OTHERWISE)	
SIDE EFFECTS	
ACTION TO BE TAKEN IN EVENT OF AN EMERGENCY/CRISIS	

CONTACT DETAILS Please ensure we are kept informed of changes to the following numbers should they change

PARENT/CARER TEL NO(S)			
PARENT/CARER TEL NO(S)			
ALTERNATE CONTACT			
DOCTOR		CONTACT NUMBER	
CONSULTANT/PAEDIATRICIAN		CONTACT NUMBER	
0ANY OTHER RELEVANT CONTACT INFORMATION			

I hereby give the school consent to treat my child for the above condition and administer medication as detailed above. I am aware that it is my responsibility to update school of changes to this information.

SIGNED ______________________________ **DATED** ______________________________