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| **Medical Consent Form**  |
| **Name of Learner:**  |   |
| **Does your child suffer from any conditions requiring medical treatment? Yes/No**  |
| **I consent to paracetamol being administered by school following verbal consent. Yes/No** |
| Condition:  | Treatment:  |
| Please give details:  | Dosage:  Self-administered: Yes/No  |
| **Please continue on an additional sheet if necessary. If asthma is a condition please complete separate sheet.**  |
| Does your child have any allergies? Yes/No Please note that school dinners may contain traces of nuts  |
| Allergy  | Medicine/Treatment  |

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| Please give details:  Complete Individual Healthcare Plan if medication is required  | Dosage:  Self-administered: Yes/No  |
| Does your child have any special dietary requirements? Yes/No  |
| If yes, please specify   |
| Does your child need to wear glasses? If yes we have discussed making sure that they always have a pair in school. | Yes/No |
| I give consent for my child to be treated by a medical professional if they become ill whilst at Reach and I cannot be contacted. | Yes/No  |
| I consent to Reach staff administering additional medication (which I have provided in the original container that it was dispensed in) to my child and understand that I am responsible for providing the school with up-to-date information about dosage and possible side effects etc. | Yes/No  |
| I am aware that if my child refuses to take their medication, staff cannot force them to and I will be informed as soon as possible.  | Yes/No  |
| I am aware that the safeguarding, attendance and positive behaviour policies are available on line and I can discuss these with a member of staff on request, I am aware of my role in supporting my child to succeed.  | Yes/No  |
| I give consent to allow my child (who is diagnosed with asthma) to use the school’s emergency inhaler (Complete Individual Health Care Plan Form).  | Yes/No  |
| I give consent for Reach staff to contact the doctor concerned for further information and to request a health care plan if needed (if your child suffers from an allergy or medical condition named above).  | Yes/No |
| Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  Parent Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

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| **Individual Healthcare Plan** |
| Child’s name: |   |
| Date of birth: | Class: Year: |
| Home address:  |   |
| Medical diagnosis/condition/symptoms |   |
| Daily Care Requirements |   |
| Describe what constitutes an emergency for the child and the action to take if this occurs |   |
| Review date |   |
| GP Name |   |
| GP address |   |
| GP Tel No |   |
| Hospital Tel no and contact name |   |
| Responsible staff providing support in school |   |
| Family Contact Information1. NameRelationship | Home: Work:Mobile: |

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| 2. NameRelationship | Home: Work:Mobile: |
| Medicine type as described on the container: |   |
| Date dispensed: | Expiry date: |
| How much to give: | Method: Oral/Inhaler/Other please state: |
| When to be given: | Self-administration: Yes / No |
| Parent Signature …………………………………………………………Parent Print Name …………………………………………………….  | Date ………………………… |