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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 Information  1. Name  Relationship | Home: Work:  Mobile: |

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| 2. Name  Relationship | 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 ………………………… |