IHP
Individual Healthcare Plan

Student Medical Details.
Parental agreement for Castle Hall Academy to administer medicine.

1. Student Identification Details

Student - Name	
Date of birth	
Gender	
Address	
Year Group	

Please Note:

Medicines must be in the original container as dispensed by the pharmacy.

2. Student Medical Needs

Medical diagnosis or conditions.	
Describe medical needs. (Give details of child's symptoms, triggers, signs, treatments, environmental issues etc.)	
Equipment, devices or facilities required.	
Staff Training needed - who, what, when	

3. Medication

Medicine Name/type of medicine (as described on the container)	
Dosage and method	
When to be taken	
Self-administration?	**Yes** ☐ **No** ☐
Expiry Date	
Side Effects/ Other information	
Action to be taken in event of emergency	

Medicine Name/type of medicine (as described on the container)	
Dosage and method	
When to be taken	
Self-administration?	**Yes** ☐ **No** ☐
Expiry Date	
Side Effects/ Other information	
Action to be taken in event of emergency	

Additional details required - Please turn over.

5. Emergency Contact Details

Parent/ Carer	Name	
	Phone—Mobile/Home	
	Phone—Work	
Other Contact	Name	
	Phone—Mobile/Home	
	Phone—Work	
Doctor	Name	
	Surgery Address	
	Telephone	
Pharmacy	Pharmacy Address	
	Telephone	
Other relevant Health professional	Name	
	Address	
	Telephone	

6. Parental consent and review

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Castle Hall Academy staff administering medicine in accordance with the Academy policy. I will inform the Academy immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that I must deliver the medicine personally to: Mr Peter Norcliffe - Medical Coordinator.

I give permission for my child to be administered with paracetamol.	**Yes** ☐ **No** ☐
I give permission for my child to be administered with an Academy Emergency Asthma Inhaler if they cannot use their own.	**Yes** ☐ **No** ☐
I give permission for my child to be administered with an adrenaline autoinjector (AAI) in an emergency. *(Students with Allergy action plans only)*	**Yes** ☐ **No** ☐

Signed by Parent/Carer:_____ **Date:** _____ /_____/_____

Form copied to SIMS?	**Yes** ☐ **No** ☐	*Office use only*

Updated January 2024—PNE