



IHP

Individual Healthcare Plan

Student medical details and parental consent form

1. Student identification details

Student - Name		Year Group/Form	
Date of birth		NHS Number	
Gender		Blood Type	
Address			

2. Student medical needs

Medical diagnosis/ conditions/ allergies	
Describe medical needs: (symptoms, triggers, signs, treatments etc.)	
Equipment, devices or facilities required	
Staff Training needed: - who, what, when	

3. Medication (Please note: Medication must be in the original container as dispensed by the pharmacy)

Name/type of medication (as described on the container)	
Dosage and method	
When to be taken	
Self-administration?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Expiry Date	
Side Effects/ Other information	
Action to be taken in event of emergency	

Name/type of medication (as described on the container)	
Dosage and method	
When to be taken	
Self-administration?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Expiry Date	
Side Effects/ Other information	
Action to be taken in event of emergency	

4. Dietary requirements

Gluten Free (GF) <input type="checkbox"/>	Halal (H) <input type="checkbox"/>	Kosher (K) <input type="checkbox"/>	Lactose Free (LF) <input type="checkbox"/>	Vegan (V) <input type="checkbox"/>	Vegetarian (Vg) <input type="checkbox"/>
Other dietary information: _____					

5. Emergency contact details

Parent/Carer	Name		Relationship	
	Phone—Mobile/Home			
	Phone—Work			
Other Contact	Name		Relationship	
	Phone—Mobile/Home			
	Phone—Work			
Doctor	Name			
	Surgery 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 to administer medication 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 medication is stopped.

I understand that medication must be in the original container as dispensed by the pharmacy and must be delivered by the parent or carer to Mr Peter Norcliffe - Medical Coordinator.

Emergency consent: - I give consent for my child to receive first aid and for staff to call 999 in an emergency.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Paracetamol: I give permission for my child to be administered with paracetamol if required.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma: I give permission for my child to be administered with an Academy emergency asthma inhaler if they cannot use their own.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergic reaction: I give permission for my child to be administered with an adrenaline autoinjector (AAI) in an emergency.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Parent/Carer Name: _____

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

Form copied to Bromcom? Yes <input type="checkbox"/> No <input type="checkbox"/>	Office use only
--	-----------------