office@highcliffeschool.com
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Tel: 01425 273381

Parkside, Highcliffe
Christchurch
Dorset, BH23 4QD

Student Health Care Plan

DATE:		
REVIEW DATE:		
NAME & DOB:		*(Insert Photo)*
TUTOR:		
STUDENT'S ADDRESS:		
MEDICAL CONDITION/S:		
MEDICATION INC. STRENGTH:		

CONTACT 1 – NAME:	
RELATIONSHIP TO STUDENT:	
MOBILE:	
HOME:	
WORK:	
CONTACT 2 – NAME:	
RELATIONSHIP TO STUDENT:	
MOBILE:	
HOME:	
WORK:	

GP DETAILS: (Name, Address and Tel. No.)	
CONSULTANT DETAILS: (Name, Address and Tel. No.)	

PERSONNEL RESPONSIBLE FOR PROVIDING SUPPORT IN SCHOOL/ RESPONSIBLE IN CASE OF EMERGENCY:

SIGNS & SYMPTOMS, TRIGGERS, TREATMENTS, FACILITIES, EQUIPMENT OR DEVICES, ENVIRONMENTAL ISSUES:

MEDICATION: DOSAGE, WHEN TO BE TAKEN, METHOD OF ADMINISTRATION, SIDE EFFECTS, CONTRA-INDICATIONS, ADMINISTERED BY/SELF – ADMINISTERED WITH/WITHOUT SUPERVISION:

DESCRIBES WHAT CONSTITUTES AN EMERGENCY AND THE ACTION TO TAKE SHOULD THIS OCCUR:

ARRANGEMENTS FOR SCHOOL VISITS/TRIPS ETC:

OTHER INFORMATION:

FORM COPIED TO & DATE :		

……. **Mr Patrick Earnshaw, Headteacher**

…… **Miss Emma-Kate Rickard, Medical Officer**

Name/s Parent/s

Name: …… **Signature: ……..**

Name: …….. **Signature: ……..**

Date ……..