Medication Health Care Plan

					INSERT PHOTO	
YOUNG PERSONS NAME:					D.O.B:	
ADDRESS:						
NEW BRIDGE SETTING: (please tick)	SCHOOL	LC	HWA	SCH1	SCH2	NBH
DATE OF COMPLETION:		BY WHOM:		STAFF INVOLVED		
MEDICAL CONDITION:						
ALLERGIES:						
NAME OF MEDICATION:						
HOW THE MEDICATION IMPACTS ON THE CHILD MEDICAL NEEDS						
DOSE:		TIME:		ROUTE		
ADVERSE REACTION TO MEDICATION/SIDE EFFECTS TO MEDICATION						
EMERGENCY CONTACT (Mobile/home/work phone number)						

Consent to Administer Medication

New Bridge Group will not give your child medicine unless you complete and sign this form. All medication will be administered in line with agreed policies.

INSERT PHOTO

School cannot be held responsible for any treatment given or not given if the young person's up to date health care plan or other health/medical needs have not been disclosed at the parent's request.

1.	I confirm I am the parent/guardian for this child and I am able to give authority for the Administration of the medication.
2.	I agree to my child _____receiving medication and/or treatment as documented in the health care plan whilst in the care of school staff.
3.	I will provide the school with a letter from the GP/Consultant if medication is changed or stopped.
4.	I understand this is a service, which the school is not obliged to undertake if appropriate information has not been supplied.
5.	I understand I am responsible for ensuring the appropriate medication is available to the school. I authorise school staff to contact my GP and other health professionals involved with my child.

Medicines must be prescribed by a doctor or dentist and sent to school in the original container with the pharmacy dispensing label attached and information leaflet enclosed.

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

Medicines bought 'over the counter' from a pharmacy will not be administered.

If more than one medicine is to be given a separate consent form should be completed for each one.

Parent/Carer signature:	
Parent/Carer Print Name	
Dated:	
Date this plan will be reviewed:	