



## Form 2 - Healthcare Plan (Long Term Medication)

Name of School/Setting: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Date of Birth: 

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Class/Form: 

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Childs Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Diagnosis or Condition: \_\_\_\_\_  
\_\_\_\_\_

Date: 

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Review Date: 

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### Contact Information:

Family Contact 1: Name		Family Contact 2: Name	
Phone No (Work)		Phone No (Work)	
Phone No (Home)		Phone No (Home)	
Mobile		Mobile	

### Clinic/Hospital Contact:

Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

PTO



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### G.P Details:

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Describe medical needs and give details of the child's symptoms:

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Daily care requirements: (e.g. before sport/at lunchtime):

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Describe what constitutes an emergency for the child, and the action to take if this occurs:

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Follow up care: \_\_\_\_\_

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Who is responsible in an emergency (state if different for off-site activities):

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**Parent Signature:** \_\_\_\_\_