



## Coleraine Grammar School

### Medication Plan for a Pupil with Medical Needs

<b>Date:</b>	<b>Review Date:</b>
<b>Name of Pupil:</b>	
<b>Year / Class</b>	
<b>Date of Birth:</b>	
<b>National Health Number</b>	
<b>Medical Diagnosis</b>	
<b>Contact Information</b>	
1. Family Contact 1	
Name	
Phone No      Home / Mobile	
Work	
Relationship:	
2. Family Contact 2	
Name	
Phone No      Home / Mobile	
Work	
Relationship:	
3. GP	
Name	
Phone No	
4. Clinic / Hospital Contact	
Name	
Phone No	
<b>Plan prepared by:</b> Mr T A Hamilton	

Describe condition and give details of pupil's individual symptoms	
Daily care requirements (if any) e.g. before sport, dietary etc	
Member of staff trained to administer medication for this child (state if different for off site activities)	
Describe what constitutes an emergency for the child, and the action to be taken if this occurs.	
Follow up care required	
I agree that the medical information contained in this form may be shared with individuals involved with the care and education of _____ Print Name _____ Date _____ Signed _____ <i>Parent / Carer</i>	
Designation: Pastoral Vice Principal	Date September 2023