Rainey Endowed School Individual Medication Plan

Student Details			
Student Name		Tutor Group	
Date of Birth		Medical Diagnosis	
Plan Prepared By		Designation	
Date		Review Date	

Contact 1 Details		Contact 2 Details	
Name		Name	
Home Number		Home Number	
Work Number		Work Number	
Mobile Number		Mobile Number	
Relationship to student		Relationship to student	
GP Contact Details		Hospital Contact Details (if relevant)	
GP Name		Named Contact	
Surgery Name		Hospital Name	
Phone Number		Phone Number	

1	Describe the condition and please give details of the student's individual symptoms.
2	Outline daily care requirements (e.g. before sport, dietary, therapy, nursing needs).
3	Describe what constitutes an emergency for the child, and the action to be taken if this occurs.
4	Student responsibilities:
5	Parental responsibilities:

I agree that the medical information contained in this plan may be shared with individuals involved with the care and education of_____(student name).

Parental Signature:_____Date:

Student Signature:_____Date:

This original should be retained on the school file and a copy sent to the parents by RES First-Aider to confirm the Individual Medication Plan for the named student.