Appendix 1 – Template letter to parents regarding completion of an IHP

Dear Parent/Carer

Re: Individual Healthcare Plan

Thank you for informing us of your child's medical condition. As part of accepted good practice and with advice from the Department for Education, and the school's governing body, our school has a Supporting Pupils at School with Medical Conditions policy. A copy of the policy is available from the school on (area code) school telephone number or school email address.

As part of this policy, we ask all parents of children with a medical condition to help us by completing an Individual Healthcare Plan for their child/children. Please complete the plan, with if necessary the assistance of your child's healthcare professional, and return it to the school. If you would prefer to meet someone from the school to complete the Individual Healthcare Plan or if you have any questions then please contact us on **(insert school contact number).**

Your child's completed plan will store helpful details about your child's medical condition, current medication, triggers, individual symptoms and emergency contact numbers. The plan will help the school staff to better understand your child's individual condition.

Please make sure the plan is regularly checked and updated and the school is kept informed about changes to your child's medical condition or medication. This includes any changes to how much medication they need to take and when they need to take it.

I look forward to receiving your child's Healthcare Plan.

Thank you for your help.

Yours Sincerely

Headteacher

Appendix 2 – Individual Healthcare Plan for Pupils with Medical Conditions at School (IHP)

(Please note a prescribed medicine in school consent form must also be completed)

1. Pupil information

Name of school_____Class/form_____

Name of pupil _____

Date of birth_____ ☐ male ☐ female

Member of staff responsible for home-school communication _____

2. Contact information

Pupil's address _____

Post Code _____

Family Contact 1

Name_____

Phone (day)_____ Mobile _____

Phone (evening) _____

Relationship with child_____

Family Contact 2

Name_____

Phone (day)_____ Mobile _____

Phone (evening) _____

Relationship with child_____

GP Name_____Phone_____

Specialist Contact Name_____ Phone _____

Medical Condition Information

3. Details of pupil's medical conditions

Signs and symptoms of the pupil's condition

Triggers or things that make this pupil's condition/s worse:

4. Routine / daily healthcare requirements

(For example; dietary, therapy, nursing needs or before physical activity)

5. Specific support for pupil's educational, social and emotional needs

6. What to do in an emergency

7. Regular medication taken during school hours

Medication 1	**Medication 2**
Name/Strength	Name/Strength
Dose and method of administration	Dose and method of administration
When it is taken (time of day)?	When it is taken (time of day)?

_____ _____

Are there any contra-indications
(signs when medication should not be given)?

_____

_____

Self-administration: can the pupil administer the medication themselves?

☐Yes ☐ No ☐ yes, with supervision by:

Staff member's name

_____

Are there any contra-indications
(signs when medication should not be given)?

_____

_____

Self-administration: can the pupil administer the medication themselves?

☐Yes ☐ No ☐ yes, with supervision

by: Staff member's name

_____

Spare / back up supply of medicine to be provided e.g. inhalers / adrenaline pen
YES / NO (If yes state location- not advised to be held by child)

_____

_____

Spare / back up supply of medicine to be provided e.g. inhalers / adrenaline pen
YES / NO (If yes state location- not advised to be held by child)

_____

_____

8. Emergency Medication

(Please complete even if it is the same as regular medication)

Name/type of medication (as described on the container):

_____

_____

_____

Describe what signs or symptoms indicate an emergency for this pupil

_____

_____

_____

Dose and method of administration (how the medication is taken and the amount)

_____

_____

Are there any contraindications (signs when medication should not be given)?

_____

_____

Are there any side effects that the school needs to know about?

_____

_____

Self-administration: can the pupil administer the emergency medication themselves?

Yes ☐ No ☐ ☐ yes, with supervision by:

Staff member's name

_____

Spare / back up supply of medicine to be provided e.g. inhalers / adrenaline pen

YES / NO (If yes state location)

_____

Is there any follow up care necessary?

_____

_____

_____

Who should be notified if emergency medicines required?

Parents ☐ Specialist ☐ GP ☐

_____

9. Regular medication taken outside of school hours

(For background information and to inform planning for residential trips)

Name/type of medication (as described on the container):

_____

_____

_____

Are there any side effects that the school needs to know about that could affect school activities?

_____

10. Members of staff trained to administer medications for this pupil

Regular medication

_____

Emergency medication

_____

11. Specialist education arrangements required
(E.g. activities to be avoided, special educational needs)

_____

_____

12. Any specialist arrangements required for off-site activities
(Please note the school will send parents a separate form prior to each residential Visit/off-site activity)

_____

_____

13. Any other information relating to the pupil's healthcare in school?

_____

_____

14. Form copied to:

_____

Parental and pupil agreement
I agree that the medical information contained in this plan may be shared with individuals involved with my/my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing.

Signed _____ Date_____
Pupil

Print Name_____

Signed_____ Date_____

Parent (if pupil's age is below16)

Print name_____

Appendix 3 – Administration of Prescribed Medicines in School Consent Form

Part A – Details of Pupil who requires Medicine to be administered at school (<u>to be completed by the parent/carer)</u>

This form must be completed by the parents of children to ask the Headteacher if prescribed medicine can be administered to their son/daughter whilst they are at school.

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

School	

The school will not give your child medicine unless you complete and sign this form, and the Headteacher has agreed that school staff can administer the medication.

My son/daughter requires their prescribed medicine to be administered at school.

Surname:		Forenames:	
Home Address:			
Date of Birth:		Class/Form:	
Condition or illness:			

MEDICINE DETAILS:

Name/Type of medicine (as described on the container)	
Name and address of the Prescriber (GP) of the medicine	

Date when the medicine was dispensed:		Starting date of the medicine:		Ending date of the medicine:	
Expiry Date of Medicine					

FULL DIRECTIONS FOR USE – NB Medicines must be supplied in their original container as dispensed by a pharmacy labelled with your child's name and clear instructions for use. Product must be in date

Dosage and amount to be given (as per label)	
Method of administration: In the case of liquid medicines a suitable measuring device to administer the required doseshould be supplied.	
Timing of administration	
Special precautions	
Side effects	
Procedures to be taken in an emergency:	
Self-Administration Yes / No/Yes with supervision	
*Request my child is able to to carry their own asthma Inhaler/ adrenaline pen/diabetes device Yes / No	

Child must be able to competently self-administer their medicine without supervision.

CONTACT DETAILS:

Name:	to the pupil:	Relationship	
Home address:			
Daytime Contact number:			

Where the school considers a Healthcare Plan is required then it should be completed.

Part B – Parent Undertaking

I understand that I must deliver the medicine personally to

In the case of children uses LA provided transport to school I understand I must deliver the medicine to the escort or driver with a completed copy of this form.

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

I/We will personally further supplies of medicine to the nominated member of staff at school before the current supply expires.

I/We accept this is a service which the school is not obliged to undertake.

I /We where relevant will ensure that second devices e.g. adrenaline pen will be provided.

I/We will be responsible for receiving the discontinued / expired medicine from the school. If we do not collect expired or discontinued medicine from school within 14 days of being asked to do so we understand this will be disposed of by the school.

Signature(s)		Date	

Relationship to the pupil:

Part C – To be Completed by the School (copy returned to parents)

1. FOR PUPILS WHO REQUIRE PRESCRIBED MEDICINE TO BE ADMINISTERED AT SCHOOL

I agree that (name of pupil)	
Will receive (quantity and name of the medicine)	
at (times of administration)	
Your child will be supervised whilst they take their prescribed medicine by the following members of staff:	
You must personally bring your child's prescribed medicine to school and hand it to (*insert name*)	
Your child's prescribed medicine will be stored in the following location:	

This arrangement will continue until the end date of the medicine or until instructed by the parents.

2. FOR PUPILS WHO ARE PERMITTED TO CARRY AND SELF ADMINISTER THEIR OWN PRESCRIBED ASTHMA MEDICATION/DIABETIC DEVICE/ ADRENALINE (EPINEPHRINE) PEN (secondary schools only) AT SCHOOL

I agree that (name of pupil)	

Will be allowed to carry and self-administer their prescribed asthma medicine / adrenaline pen / Diabetic device whilst in school and that this arrangement will continue until

Signed: Headteacher		Date:	

The school will not give your child medicine unless you complete and sign this form and the Headteacher has agreed that school staff can administer the medication.