THE SPALDING
SPECIAL SCHOOLS FEDERATION
THE PRIORY SCHOOL
Achieving Together

Health Care Plan

Name :

D.O.B:

Class:

Contact Information

Mother:

Father:

Other Relative:

Family Doctor:

Medication taken and dosage (taken in school)

Name of medication

How much

Time to be taken

Start date Finish date

Medication to be sent home daily / Medication to stay in school (please delete)

Continue over

Details of condition

Agreement signed by Parent/ Carer

Name...Signature....................................
....

Date...

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