THE SPALDING SPECIAL SCHOOLS FEDERATION
THE PRIORY SCHOOL
Achieving Together

HEALTH CARE PLAN

Name: ……

Date of Birth: ……..

Class: ……

Contact Information

Mother: ……...

Father: ……

Other relative: ……

Doctor: ……

Medication and dosage to be taken in school

Name of medication: ……

Dosage: ……..

Time to be taken: ……..

Start date: …… Finish date ……..

Medication to be sent home daily / Medication to remain in school (please circle)

Details of condition

……

……

I confirm that the above information is correct and that staff can administer the medication to my child.

Signature of Parent/Guardian ……

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