

GHYLLSIDE OUT OF SCHOOL CLUB
HEALTH CARE PLAN
2018 - 2019

PLEASE COMPLETE THIS FORM IF YOUR CHILD IS TAKING LONG TERM MEDICATION, SUFFERS FROM ALLERGIES, ASTHMA, EPILEPSY OR DIABETES.

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| CHILD'S NAME | |
| DATE | |
| NATURE OF CONDITION | |
| MEDICATION | Will Ghyllside Out of School Club need to administer medication? |
| | If yes, how is the medicine administered? |
| | Where is the medication stored? |
| | In the event of your child not gaining immediate relief from the medication, what course of action should staff take? |
| DATE FOR REVIEW | |
| PLEASE INCLUDE ANY FURTHER INFORMATION THAT YOU THINK IS RELEVANT | |
| | |

Signature of Parent/Carer

Date