Our Lady's Grove Primary School

Underlying Medical Condition/Allergies

Junior Infants 2021– Class of 2029

For Office Use:

Teacher's Name: ____ Room No: ______________

Child's Information

Name of Child: ___________________________ Class: _________

Date of Birth: ____________________________ Age: ___________

Address: ____

____

Siblings in the School:

Name: _________________________________ Class: _______________

Name: _________________________________ Class: _______________

Family Contact 1:

Name: ____

Phone (day) Mobile: ______________ Phone (evening)_________________

Relationship to student: ____

Family Contact 2:

Name: ____

Phone (day) Mobile: ________________Phone (evening)_______________

Relationship to student: ____

GP/Family Doctor:

Name: ___________________________ Phone: _______________________

Consultant

Name: ___________________________ Phone: ________________________

3. Details of the child's condition(s) signs and symptoms

____

____

____

Triggers or things that make this student's condition(s) worse:

____

____

4. **Regular Medication**

____

____

____

____

____

5. Activities - Any special considerations to be aware of?

____

____

6. Any other information relating to the child's health care in school?

____

____

____

The school may contact the person named below for further information or training.

7**. Name of Hospital Nurse for the child**

Name: ____

Address: ______________________________________

Phone: ____

Parent/Guardian Signature: _____________________________________

Date: ______________________

Parental agreement (please tick the correct reply)

I agree ☐ or I do not agree ☐ that the medical information contained in this plan may be shared with individuals involved with my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing.

Signed by parent: ____

Print name: ____

Date: ____

Permission for emergency medication (please tick correct reply)

In the event of an emergency, I agree ☐ or I do not agree ☐ with my child receiving medication administered by a staff member or providing treatment.

I understand that the staff /school will not be responsible for any incident/issue that may arise to the administration and/or non-administration of this medication.

Signed by parent: ____

Print name: ____

Date: ____

Emergency Medication Provision School Record

The Board of Management has agreed this plan during the meeting held on

______________________________ ______________

Chairperson Date
Board of Management

The information contained in this form will be processed following GDPR regulations.