ST ANDREW'S CE (VA) JUNIOR SCHOOL

PUPIL/ STAFF CARE PLAN

FOR PUPIL/ STAFF WITH MEDICAL NEEDS (OTHER THAN ASTHMA)

NAME:	**DOB:**

(Photo here)

Date of Plan:
Compiled by:

Review Date:
Reviewed by:

Next review date:

Condition:

Symptoms: *(please include details of any triggers)*

Actions/ agreed procedures: *(Please include details here of who we should contact if your child refuses to take their medication)*

Emergency procedures:

Signed …….. Date ……

Name …… Relationship to child……