St John's Church of England School

Headteacher - Mrs J Hester

'I can do everything through Christ, who gives me strength'
Philippians 4:13

Allergy Health Care Plan

Name of child:	
Date of birth:	
Class:	
Address:	
Parental Emergency Contact	Name: Tel: Mobile No: Email:
2nd Emergency Contact	Name: Tel: Mobile No: Email:
Doctor/Nurse	Name: Address: Tel:

TREATMENT:

I can confirm that my child is allergic to:	(please state clearly)	
Has your child been tested by GP/Hospital:	YES	NO
When was the last time they had a reaction:		
The signs and symptoms that the child may experience during an allergic reaction are:		
What triggers his/her allergy:		
Name of medication:		
How much and how often:		
Medication expiry date:		

CONSENT:

I give permission for the prescribed medication named overleaf to be administered to my child should the need arise.	YES	NO
I understand that it is my responsibility to provide the School with spare "in date" emergency medication.	YES	NO
I give permission for the school to use their emergency medication (**Blue Inhaler**) in an **emergency only,** should the need arise.	YES	NO
I understand that it is my responsibility to inform the school **immediately** of any changes to my child's medical condition or treatment.	YES	NO

Signed……(parent/carer)

Name of parent/carer **please print**……..

Date……..

Office use only

Medication received from parent Yes/No

Form completed in full Yes/No

Date care plan received…… Update due……

Signed……