

# DOORUS N.S.

Doorus, Kinvara, Co.Galway

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## Healthcare Plan for a student with a medical condition at school

Date form completed: \_\_\_\_\_ Date for review: \_\_\_\_\_

### 1. Student's Information

Name of Student: \_\_\_\_\_ Class: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

### 2. Contact Information

Student's Address: \_\_\_\_\_  
\_\_\_\_\_

### FAMILY CONTACT 1

Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Mobile: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

**FAMILY CONTACT 2**

Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Mobile: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

**FAMILY CONTACT 3**

Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Mobile: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

**GP**

Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_

**3. Details of the student's condition**

Signs and symptoms of this student's condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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**4. Regular Medication taken during school hours(including dosage required):**

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Is the child to be responsible for taking the medication him/herself? Yes  No

**5. Emergency medication – Please fill our full details including dosage:**

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**6. Storage details:**

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**7. Activities – Any special considerations to be aware of?**

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**8. Any other information relation to the student's healthcare in school?**

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