the migraine trust

Template

Individual Healthcare Plan for Migraine Sufferers

Pupil's information

Pupil's Name……..School Name…….....

Pupil's Main address……Class/Form……

Date of Birth …… Form Teacher……..

Male/female (delete as applicable)

Emergency contact information

Emergency contact 1	**Emergency contact 2**
Name……..……..	Name…….....
Relationship with child ……	Relationship with child…….....
Phone (home) ……..	Phone (home) ……..……
Phone (mobile) ……..	Phone (mobile) ……
Phone (work) …….....	Phone (work) ....…….....
Email ……	Email …….

Other essential information concerning your child

GP/Special Nurse Name……. Telephone no…..…….

SEN co-ordinator (if applicable) Name…… Telephone no……...

Medical details

Type of migraine condition

……

Symptoms……

……..

Triggers……

……

Treatment ..……..

……

Further details (frequency, duration and so on) ……..

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Allergies ……

Other condition(s)……..

Agreed adjustments……..

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(Continue on a separate sheet if necessary)

What to do when an incident/emergency occurs (medication, contact and so on)

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(Continue on a separate sheet of necessary)

What to do when the pupil is unable to attend school due to a migraine attack (who to contact, work provided, extra tuition and so on)

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Medication

Name (as on the container/packaging) ……

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Prescribed dose/method ……..

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When to administer (set intervals/emergency and so on) ……

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Known side effects ……

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Staff member responsible for medication ……..

Self administration (yes/no/with supervision) ……

Additional information ……

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School trips or other activities

Arrangements for school trips/activities outside normal school timetable ……..…

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Staff training requirements

Staff training needs/required ….……

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Further information

Additional information and arrangements (contact requirements, family circumstances, out of school hours details and so on)

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Review

Date completed …….. Review date…….....

Agreement

I agree that the information in this healthcare plan is accurate and up to date. I understand that the information in this document will be shared with the relevant professionals involved in my/my child's education and at times external professionals (such as the emergency services) for the purposes of the health and safety of my child. I agree to inform the school as soon as possible of any changes which affect this healthcare plan.

I agree that:
☐ The school will be responsible for the storage of my/my child's medicines and it will be stored in accordance with the schools policy.
☐ The school will be responsible for administering my/my child's medication at required intervals/in emergencies as stated in this healthcare plan.
☐ I agree that I/my child can keep my/their medication on my/their person and have responsibility for the use of this when required.
Additional notes

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Signed (pupil) …….. Date ……..

Print name…….....

Signed (parent/guardian) ……Date ……..

Print name ……

I agree that the information in this plan is accurate and up to date.

Signed (healthcare professional) …… Date ……

Print Name ……

Job title ……

I agree, on behalf of the school, to the procedures, including management of medication, outlined in this healthcare plan and am responsible for ensuring the necessary action is taken by the school. I agree to inform the relevant parties and review the healthcare plan in the event that any changes occur which may affect this agreement.

Signed (Head teacher) …….. Date ……

Print Name ……