Heston
COMMUNITY
SCHOOL

STUDENT MEDICAL INFORMATION

Student's Name	
Date of Birth	
Year / Reg Group	

This document will enable Heston Community School to provide the correct medical care for your child.

Please complete all of the relevant sections in CAPITAL LETTERS.

Should you need further help in completing this form, please contact,
Heston Community School, Heston Road, Hounslow, Middlesex, TW5 0QR
Tel: 0208 572 1931, info@hestoncs.org

Should your child's condition change, you must notify the School immediately.

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Student Services

Student Services offer a wide variety of care and support to all students that attend Heston Community School.

We have appointed First Aiders, specifically trained to give basic first aid until, if necessary, emergency services arrive on the scene.

Student Services aim to encourage resilience and promote good attendance in School. We will offer other forms of basic medical treatments and services to students when required.

Treatments and services offered are shown in the table below. Please provide your consent as necessary giving any additional information about any allergies.

Treatment / Service	Consent
Paracetamol One 500mg tablet. Also available in liquid form x10ml, for headaches, period pains cold symptoms and general pain relief.	☐ I **AGREE** that Paracetamol may be given to my child by a trained First Aider whilst at School. ☐ I **DO NOT AGREE** to Paracetamol being given to my child whilst at School.
- **Kool/Heat Spray** for Sprains and Muscle Pain - **Arnicare** – For Bruising - Sprays and Creams for Bites and Stings - Burn Plasters and Gels for Burns - Plasters for Cuts and Blisters - Ice Packs for Lumps and Bumps Throat Lozenges	I **agree/disagree** for a trained First Aider to give/use any of the additional treatments to my child whilst at School. Please indicate your consent below. ☐ I Agree ☐ I Disagree ☐ I Agree ☐ I Disagree ☐ I Agree ☐ I Disagree ☐ I Agree ☐ I Disagree ☐ I Agree ☐ I Disagree ☐ I Agree ☐ I Disagree ☐ I Agree ☐ I Disagree
Hay fever / Allergy Remedies **Cetirizin**e or **Piriton** These remedies are also used for skin, pet and dust mite allergies.	**Does your child suffer with hay fever?** ☐ **Yes** - If your child regularly requires hay fever medication, please provide separately and complete the **Record of Medication**. ☐ I **AGREE** that a trained First Aider can administer hay fever/allergy treatments listed, to my child whilst at School. ☐ I **DO NOT AGREE** to these additional treatments being offered to my child.
- Facial makeup remover wipes - Nail varnish remover - Nail clippers	☐ I **AGREE** that the treatments listed may be given to my child whilst at School. ☐ I **DO NOT AGREE** - Please note that your child will be sent home, should they refuse to remove make-up, nail varnish or fake nail accessories.
Please state any known allergies to any of the above.	
Child's Name: _____ Year/Reg Group: _____ Parent/Carer's Name: _____ Relationship: _____ Signature: _____ Date: _____	

Prescribed Medications

On occasions, your child may be prescribed with antibiotics or other medication from your Doctor.

Where medication is prescribed to be taken three times a day, we would suggest that you keep them at home and administer them in the morning, on their return home from School and the final dosage before bedtime.

If your child requires medication more frequently during the day, we must store the medication in the Welfare Office and administer it if necessary with your consent.

I **AGREE** that, medications prescribed by a Doctor, can be given to my child whilst attending School, by our trained First Aiders. I will ensure that medications are renewed once they go past their expiration date.
Child's Name: _____ Year/Reg Group: _____ Parent/Carer's Name: _____ Relationship: _____ Signature: _____ Date: _____

HEALTH CARE PLAN

Please complete the form below for other Medical Conditions

Name of School	Heston Community School
Child's Name	
Child's Tutor Group	
Medical Diagnosis or Condition	
Would you like to discuss this further with Student Services?	☐ YES ☐ NO
For School Use Only Parents contacted and Healthcare Plan review date.	☐ YES ☐ NO
Clinic/Hospital Contact Name Telephone Number	
Describe medical treatments and give details of your child's symptoms.	
Daily Care Requirements	
Describe what constitutes as an EMERGENCY and what action to take should this occur.	
Specific support for the student's education, social and emotional needs.	
Are there any special arrangements that we need to consider for your child during school trips and visits?	

RECORD OF MEDICATION

Medication _____

How Often _____

Time to be Given _____

Dosage _____

Further Information _____

_____

_____

Medication _____

How Often _____

Time to be Given _____

Dosage _____

Further Information _____

_____

_____

Medication _____

How Often _____

Time to be Given _____

Dosage _____

Further Information _____

_____

_____

☐ I agree that I will regularly update the School of any changes to my child's medical needs.
☐ I agree the information provided may be shared with the relevant members of staff and that a photograph of my child will be displayed in non-public areas in case of an emergency.
☐ I agree that the trained First Aiders can support with administering of their medication.

Child's Name: _____ Year/Reg Group: _____

Parent/Carer's Name: _____ Relationship: _____

Signature: _____ Date: _____

Asthma, Allergies or Diabetes
Health Care Plan for a Student with Medical Conditions

Student's Name: _____ ☐ Asthma ☐ Allergies ☐ Diabetes

Student Name	
Date of Birth	
Parent/Carers Name	
Home Telephone Number	
Mobile Number	
Name of GP	
GP Telephone Number	
GP Address	

☐ I agree that my child will manage their condition by carrying their medication with them at all times; for example, asthma pumps, Insulin, and allergy medication.
☐ I will also provide spare medication/equipment, which will be stored in the medical room.
☐ If my child is diabetic, I will ensure they have sugary snacks and testing kits stored in the welfare area at school.

Spare Medication provided ☐ Yes ☐ No
Expiry Date: _____

What medication does your child take for their medical condition?	
Does your child tell you when he/she needs medication?	
Does your child need help taking medication?	
What triggers your child's condition?	
Does your child need medication before exercise?	
If your child is diabetic, are they confident at managing their condition?	

☐ I agree that I will regularly update the School of any changes to my child's medical needs.
☐ I agree the information provided may be shared with the relevant members of staff and that a photograph of my child will be displayed in non-public areas in case of an emergency.
☐ I agree that the trained First Aiders can support with administering of their medication.

Child's Name: _____ Year/Reg Group: _____

Parent/Carer's Name: _____ Relationship: _____

Signature: _____ Date: _____

Please provide any other information that we should know about your child's medical condition.

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Allergy Action Plan

THIS CHILD HAS THE FOLLOWING ALLERGIES:

Name:

DOB:

Photo

Emergency contact details:

1) ☎

2) ☎

Child's Weight: Kg

PARENTAL CONSENT: I hereby authorise school staff to administer the medicines listed on this plan, including a 'spare' back-up adrenaline autoinjector (AAI) if available, in accordance with Department of Health Guidance on the use of AAIs in schools.

Signed: _____

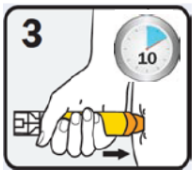
_____
(PRINT NAME)

Date:

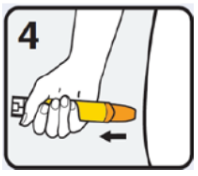
How to give EpiPen®

Form fist around EpiPen® and PULL OFF BLUE SAFETY CAP

SWING AND PUSH ORANGE TIP against outer thigh (with or without clothing) until a click is heard



HOLD FIRMLY in place for 10 seconds



REMOVE EpiPen®. Massage injection site for 10 seconds

Mild-moderate allergic reaction:

- Swollen lips, face or eyes
- Itchy / tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

ACTION:

- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- Give antihistamine:
- Phone parent/emergency contact (if vomited, can repeat dose)

Watch for signs of ANAPHYLAXIS

(life-threatening allergic reaction)

Anaphylaxis may occur *without* skin symptoms: **ALWAYS consider anaphylaxis in someone with known food allergy who has SUDDEN BREATHING DIFFICULTY**

AIRWAY:	Persistent cough, hoarse voice difficulty swallowing, swollen tongue
BREATHING:	Difficult or noisy breathing, wheeze or persistent cough
CONSCIOUSNESS:	Persistent dizziness / pale or floppy suddenly sleepy, collapse, unconscious

If ANY ONE (or more) of these signs are present:

1. **Lie child flat:** (if breathing is difficult, allow child to sit) 
2. **Use Adrenaline autoinjector** (eg. Epipen) **without delay**
3. **Dial 999** for ambulance and say ANAPHYLAXIS ("ANA-FIL-AX-IS")

***** IF IN DOUBT, GIVE ADRENALINE *****

After giving Adrenaline:

1. Stay with child until ambulance arrives, **do NOT stand child up**
2. Commence CPR if there are no signs of life
3. Phone parent/emergency contact
4. If no improvement after 5 minutes, **give a 2nd adrenaline dose** using a second autoinjector device, if available.

You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis.

Additional instructions:

If wheezy, give adrenaline FIRST, then asthma reliever puffer (blue inhaler) via spacer

This is a medical document that can only be completed by the child's healthcare professional. It must not be altered without their permission. This document provides medical authorisation for schools to administer a 'spare' back-up adrenaline autoinjector if needed, as permitted by the Human Medicines (Amendment) Regulations 2017.

This plan has been prepared by:

SIGN & PRINT NAME: _____

Hospital/Clinic: _____

☎ Date:

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