Long Term Care Plan Form

Student's name

Medical condition

Is this an ongoing condition?

☐ Yes
☐ No

Medication name(s)

Dosage of medication(s)

1. Medication use time (if applicable)

HH:HH am / pm

2. Medication use time (if applicable)

HH:HH am / pm

3. Medication use time (if applicable)

HH:HH am / pm

Self administration

☐ Yes
☐ No

Date medication(s) dispensed by pharmacy

Medication expiry date(s)

Special precautions

EXAMPLE: *Medication should be taken before/ after lunch.*

Student's condition and individual symptoms

Daily care requirements

Procedures to take in an emergency

Follow up care (if applicable)

GP Details/ medical professionals working with your child

Additional information (if needed)

Using the information provided we will create a long term care plan for your child. We will let you know when this is ready to be reviewed and authorised by you.

DETAILS OF PERSON COMPLETING THIS FORM:

Name

Date

Email address

Signed

OFFICE USE ONLY: RECORDED ON MEDICAL TRACKER: ☐