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)

2. Medication use time (if applicable)

3. Medication use time (if applicable)

Self-administration
Yes ☐ No ☐

Date medication(s) dispensed by pharmacy

Medication expiry date(s)

Special precautions

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 ☐