

Dartford Grammar School for Girls

MEDICAL CARE PLAN – 2026 - 2033

Strictly Private and Confidential

Name:		
DOB:		
Form		

INHALERS

Does your daughter/son use an inhaler for any reason?	
Why does your daughter/son use an inhaler:	
What inhaler(s) does she/he use and when:	
My daughter/son will carry her/his inhaler whilst in school.	
I will arrange for an inhaler(s) to be held in school.	
The expiry date of the inhaler is:	
Are there any special precautions/requirements the school should be aware of:	
Details of procedures to take in an emergency and what constitutes an emergency:	
Use of "spare" salbutamol inhaler: I give consent for my daughter/son to use the "spare" salbutamol reliver inhaler held in school if her/his prescribed reliever inhaler is not available:	
Does your daughter/son have an Asthma Action Plan to be held with this Medical Care Plan?	

EPIPENS

Does your daughter/son use an epipen for any reason?	
What epipen does she/he use?	
My daughter/son will carry her/his epipen whilst in school.	
I will arrange for additional epipen(s) to be held in school.	
The expiry date of the epipen is:	
Are there any special precautions/requirements the school should be aware of:	
Details of procedures to take in an emergency and what constitutes an emergency:	
Use of "spare" adrenaline device: I give consent for my daughter/son to use the "spare" adrenaline device held in school in an emergency	

ALLERGIES

Does your daughter/son have any allergies? Yes/No	
Details of any allergies/allergens requiring an epipen	
Details of any allergies/allergens NOT requiring an epipen	
How is the allergy managed?	
Is your daughter/son likely to be aware that they are having an allergic reaction?	
Is your daughter/son likely to be able to alert others that they are having an allergic reaction?	
Arrangements for support:	
Visits and trips:	
Does your daughter/son have an Allergy Action Plan to be held with this Medical Care Plan?	
Details of any other allergy medication to be held in school?	
Please provide details of other prescription allergy medication to be held in school (not epipen)	
Please state any procedures to be followed, including if this emergency medication:	
Prescribed by GP/date:	
Please confirm that parental consent is given to administer the prescription or non-prescription medication described above:	
Date of Consent:	

DIABETES

Does your daughter/son have diabetes?	
Are there any special precautions/requirements the school should be aware of:	
Details of procedures to take in an emergency and what constitutes an emergency:	
What type of diabetes does your daughter/son have?	

DIABETES - TYPE 1 (if applicable)

My daughter/son will carry spare insulin	
Parent/carer will arrange for insulin to be available in school	
The expiry date on the insulin to be held in school is:	
A testing kit and snacks will be carried by my daughter/son	

MENTAL HEALTH CONCERN

Are there any mental health concerns for your daughter/son:	
Name/description of condition	
Details of difficulties your daughter/son experiences, including any named diagnosis:	
Are there any special precautions/requirements the school should be aware of:	
Details of procedures to follow in an emergency and what constitutes an emergency:	
Details of medication to be taken and when they are taken:	
Is medication required during the school day?	
Details of medication to be taken during the school day and when it should be taken:	
The expiry date on the medication held in school:	
Confirmation from parent/carer that they will email AMA any additional or new mental health concerns:	

OTHER MEDICAL ISSUES (if applicable)

Are there any other medical issues:	
Name of condition of any other medical issues:	
Details of the difficulties your daughter/son experiences, including any named diagnosis:	
Are there any special precautions/requirements the school should be aware of:	
Details of procedures to follow in an emergency and what constitutes an emergency:	
Details of medication to be taken and when:	
Is medication required during the school day?	
Details of medication to be taken during the school day and when it should be taken:	
The expiry date on the medication held in school:	

CONFIRMATION

Parent/Carer has read their role and responsibilities:	
Parent/Carer confirmed that they have read and discussed the student role with their daughter/son:	
Parent/Carer confirmed they have read the school's role and responsibilities:	

PARENTAL CONSENT

Parent/Carer has confirmed that the information provided is accurate and will update the school at the earliest opportunity if the information changes:	
Parent/Carer has consented to medication being administered by staff who have received training:	
Name of person completing this form:	
Relationship to student of person completing this form:	
Details of any arrangements/medication for residential trips/visits that has not already been covered. Indicate n/a if not required:	

ANYTHING ELSE

Is there anything else you would like the school to be aware of if not already covered	
If there is something else please give details:	

Office Use Only: Medication received in school
2026-2027

2026-2027			
	Parent Approval Received Date		Approved By Name
Student Aware Medication Location			
	Signature	Print Name	Date
Headteacher/Assistant Headteacher: SENCO			

School staff, who have received appropriate training, will be covered by indemnity as set out by KCC guidance. (Section 10 para 2:1 and 5:2 Supporting Pupils with Medical Needs).