

Dear Parent/Guardian

I am writing to you from the Learner Services Department at City of Westminster College.

Your son/daughter/young person in your care has informed us, on his/her application form, that he/she has a medical condition that may require some support.

Please complete the forms attached and return them to a member of the Learner Services Team in the Information Centre, Paddington Green Campus. The Learner Services team will take this opportunity to meet with you and or the learner to discuss any concerns and make any necessary referrals to support staff. I would like our students to feel that we are able to make appropriate provision for their medical requirements whilst making the least possible disruption to their education, enabling a good and positive learning experience.

Any information that you provide will only be made available to those members of staff who will look after the student should it be necessary. Please ensure that we are kept updated on any changes to your contact details in case of an emergency.

If you or the student are concerned about any of the above or have any questions please do not hesitate to contact our Learner Services team via email learner.services@cwc.ac.uk or telephone 020 7723 8826.

Yours faithfully



Head of Learner Services

City of Westminster College



**STUDENT HEALTH PLAN FOR A STUDENT WITH MEDICAL NEEDS**

**Personal Details**

|  |  |
| --- | --- |
| **Student Name** | **:** |
|  |  |
| **Date of Birth** | **:** |
|  |  |
| **Medical Condition** | **:** |
|  |  |
| **Course Name** | **:** |
|  |  |
| **Tutor** | **:** |

**Emergency Contact Information**

|  |  |
| --- | --- |
| **Family Contact 1** |  |
| **Name** | **:** |
|  |  |
| **Telephone No.** | **:** |
|  |  |
| **Email** | **:** |
|  |  |
| **Relationship to Student** | **:** |

|  |  |
| --- | --- |
| **Family Contact 2** |  |
| **Name** | **:** |
|  |  |
| **Telephone No.** | **:** |
|  |  |
| **Email** | **:** |
|  |  |
| **Relationship to Student** | **:** |

|  |  |
| --- | --- |
| **G.P. Contact** |  |
| **Practice Name** | **:** |
|  |  |
| **Name of G.P.** | **:** |
|  |  |
| **Telephone No.** | **:** |

|  |
| --- |
| **Describe condition and give details of student’s individual symptoms:** |

|  |
| --- |
| **Daily care requirements: (e.g. before sport/lunchtime)** |

|  |
| --- |
| **Describe what constitutes an emergency for the student and the action to take if this occurs:** |

|  |
| --- |
| **Follow up care:** |

*Please sign this form to confirm that you give your consent for the information provided to be shared with First Aid and Safeguarding staff.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** |  | **Student Name** |  | **Student Signature** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** |  | **Parent/Carer Name** |  | **Parent/Carer Signature** |



**REQUEST FOR STUDENTTO CARRY HIS/ HER MEDICATION**

**This form must be completed by parent/guardian**

|  |  |
| --- | --- |
| **Student Name** | **:** |
|  |  |
| **Date of Birth** | **:** |
|  |  |
| **Address:** | **:** |
|  |  |
| **Condition or illness** | **:** |
|  |  |
| **Name of Medicine** | **:** |
|  |  |
| **Procedures to be taken in an Emergency** | **:** |
|  |  |
| **Course Name** | **:** |
|  |  |
| **Tutor** | **:** |

**Parent/ Carer Contact Information**

|  |  |
| --- | --- |
| **Name** | **:** |
|  |  |
| **Daytime Telephone No.** | **:** |
|  |  |
| **Mobile Telephone No.** | **:** |
|  |  |
| **Email** | **:** |
|  |  |
| **Relationship to Student** | **:** |

**I would like my son/daughter to keep his/her medication on him/her for use as necessary.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** |  | **Parent/Carer Name** |  | **Parent/Carer Signature** |