

Dear Student,

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

You have informed us on your application form that you have a medical condition. If you believe you may require support at College because of your medical condition, it is important we have some information about the condition.

Please complete the attached form and return it to a member of the Learner Services Team in the Information Centre, Paddington Green Campus or the Student Advisor at the Maida Vale Campus. A member of the Learner Services team will take this opportunity to meet with you to discuss any concerns and make any necessary referrals to support staff.

Any information that you provide will only be made available to those members of staff who will look after you 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 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 your symptoms:** |

|  |
| --- |
| **What medication are you taking regularly?** |

|  |
| --- |
| **Do you carry this medication with you?** |

|  |
| --- |
| **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** |