Individual Health Care Plan

*To be completed for each child with long term or complex medication and that the Medical Administration Form is attached*

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| --- | --- | --- | --- |
| **Name of child:** |  | **Date of birth:** |  |
|  |
| **Group / class / form / teacher:** |   | Child’s address:  |    |
|  |
| **Date plan drawn up:** |   | Date to be reviewed: **(no more than 12 months from date drawn up):**  |   |
|  |
| **Contact information: *Please complete with the details of two primary contacts for the child***

|  |  |  |
| --- | --- | --- |
| *Name* |   |   |
| *Address* |    |   |
| *Daytime number* |   |   |
| *Evening number* |   |   |
| *Relationship* |   |   |

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|  |
| **Medical contact information: *Please complete with the details of medical contacts***

|  |  |  |
| --- | --- | --- |
| *Contact* | GP  | Clinic / hospital contact  |
| *Name* |   |   |
| *Address* |    |   |
| *Phone number* |   |   |

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| **Medical condition / illness and resulting needs, including medication: *Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.*** |
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| **Daily care requirements: *i.e. sport / lunchtime / arrangements for academy trips etc.******Note down s*eparate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the child can participate, e.g. separate risk assessment if necessary** |
|  |
| **Specific support and level of support required: *For child’s educational, social and emotional needs.*** |
|  |
| **Who is responsible for providing support in the academy (and cover arrangements when they are unavailable):****Who in the academy needs to be aware of the child’s condition:** |
|  |
| **Emergency information: *Describe what constitutes an emergency for the child, and action to be taken if this occurs.*** |
|  |
| **Follow up care:** |
|  |
| **Who is responsible in an emergency (and cover arrangements when they are unavailable): *State if different on off-site activities.*** |
|  |
| **Medical Administering****Written consent received from parents for child to self-administer during school hours** |   |
| **Written consent received from parents for members of first aid team to supervise medicine to [*name of child]* during school hours** |   |
| **Written consent received from principal for child to self-administer during school hours** |   |
| **Written consent received from principal for members of first aid team to supervise medicine to [*name of child]* during school hours** |   |
| **Other information: [e.g. where confidentiality issues are raised by the parent/child, the designated individuals to be entrusted with information about the child’s condition.** |
|  |
| **Staff training needed / undertaken: *Who, what, when?*** |
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| --- | --- |
| ***Signed:*** | **Date:** |
| *Child (if appropriate)* |   |   |
| *Parent / Carer* |   |   |
| *Principal* |   |   |
| *SENCO* |   |   |
| *DSL* |   |   |
| *GP/medical professional* |   |   |

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