**Individual Healthcare Plan**

|  |  |
| --- | --- |
| Name of school |  |
| Child’s Name |  |
| Class |  |
| Date of birth |  |
| Child’s Address |  |
| Medical Diagnosis or condition |  |
| Date |  |
| Review Date |  |

**Family Contact Information**

|  |  |
| --- | --- |
| Name |  |
| Phone no (work) |  |
| (home) |  |
| (mobile) |  |
| Name |  |
| Relationship to child |  |
| Phone no (work) |  |
| (home) |  |
| (mobile) |  |
|  |  |

**Clinic/Hospital Contact**

|  |  |
| --- | --- |
| Name |  |
| Phone no |  |

**G.P**

|  |  |
| --- | --- |
| Name |  |
| Phone no |  |

|  |  |
| --- | --- |
| Who is responsible for providing support in school |  |

Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.

|  |
| --- |
|  |

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision.

|  |
| --- |
|  |

Daily care requirements

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| --- |
|  |

Specific support of the pupil’s educational, social and emotional needs

|  |
| --- |
|  |

Arrangements for school visits/trips

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| --- |
|  |

Other information

|  |
| --- |
|  |

Describe what constitutes an emergency and the action to take if this occurs

|  |
| --- |
|  |

Who is responsible in an emergency *(state is different for off-site activities)*

|  |
| --- |
|  |

Plan developed with

|  |
| --- |
|  |

Staff training needed/undertaken – who, what, when

|  |
| --- |
|  |

**Parental agreement for setting to administer medicine**

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

|  |  |
| --- | --- |
| Date for review to be initiated by |  |
| Name of school |  |
| Name of child |  |
| Date of birth |  |
| Class |  |
| Medical condition or illness |  |

**Medicine**

|  |  |
| --- | --- |
| Name/Type of medicine |  |
| Expiry Date |  |
| Dosage and method |  |
| Timing |  |
| Special precautions/other instructions |  |
| Are there any side effects that the school needs to know about? |  |
| Self-administration – Y/N |  |
| Procedures to take in an emergency |  |

**NB: Medicines must be in the original container as dispensed by the pharmacy**

**Contact Details**

|  |  |
| --- | --- |
| Name |  |
| Daytime telephone no |  |
| Relationship to child |  |
| Address |  |
| I understand that I must deliver the medicine personally to | (agreed member of staff if not self-administered) |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or is the medication is stopped.

Signature(s)

Date