

## Individual Health Care Plan



### Individual Health Care Plan

<b>Child's name:</b>	
<b>Date of birth:</b>	<b>Class:</b>
<b>Child's address:</b>	<b>Medical diagnosis or condition:</b>
<b>Family Contact Information</b>	
<b>(Adult 1) Name:</b>	<b>Relationship to child:</b>
<b>Phone no: (work / mobile)</b>	<b>Phone no: (home / mobile)</b>
<b>(Adult 2) Name:</b>	<b>Relationship to child:</b>
<b>Phone no: (work / mobile)</b>	<b>Phone no: (home / mobile)</b>
<b>Clinic / Hospital Contact</b>	
<b>Name:</b>	<b>Phone no:</b>
<b>General Practitioner</b>	
<b>Name:</b>	<b>Phone no:</b>
<b>Who is responsible for providing support in school?</b>	
<b>Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.</b>	
<b>Name of medication, dose, method of administration, when to be taken and side effects. (In addition, appendix 1 - Administration of Medication Permission Form and Record to be completed)</b>	
<b>Daily care requirements:</b>	

<b>Specific support for the child's educational, social and emotional needs</b>
<b>Arrangements for school visits / trips etc.</b>
<b>Describe what constitutes an emergency and the action to take if this occurs</b>
<b>Who is responsible in an emergency (state if different for off-site activities)</b>
<b>Other information not included:</b>
<b>Plan developed with:</b>
<b>Staff training needed / undertaken – who, what, when</b>

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

<b>Signed by parent or carer:</b>	<b>Print name:</b>
<b>Signed by staff member:</b>	<b>Print name and position:</b>
<b>Date:</b>	<b>Review date:</b>
<b>Copies to:</b>	