**Individual Healthcare Plan**

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| **Child’s Name** |  |
| **Tutor Group** |  |
| **Date Of Birth** |  |
| **Child’s Address** |  |
| **Medical Diagnosis** |  |
| **Date of Diagnosis** |  |
| **Medical Review Date** |  |
| **Date of Last Episode** |  |

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| --- |
| **Family Contact Information** |
| Name |  | Name |  |
| Relationship to Child |  | Relationship to Child |  |
| Phone Number (Work) |  | Phone Number (Work) |  |
| Phone Number (Mobile) |  | Phone Number (Mobile) |  |
| Phone Number (Home) |  | Phone Number (Home) |  |

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| **Clinic/Hospital Contact Details** |
| Name |  |
| Phone Number |  |
| Address |  |

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| **GP Details** |
| Name |  |
| Phone Number |  |
| Address |  |

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| **Who is responsible for providing support at School?** |  |

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| **Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.** |
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| **Name of Medication, does, method of administration, when to be taken, side effects, contra-indications, administered by self/administered with/without supervision** |
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| **Daily care requirements** |
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| **Specific support for the pupil’s educational, social and emotional needs** |
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| **Arrangements for school visits/trips etc** |
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| **Other information** |
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| **Describe what constitutes an emergency, and the action to take if this occurs** |
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| **Who is responsible in an emergency (state if different for offsite activities)** |
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| **Plan Developed with** |
|  |
| **Staff training needed/undertaken – who, what , when** |
|  |
| **Form Copied to**  |
|  |
| **Signed by** |
| **Job Title** |
| **Date** |
| **Signed by Parent/Guardian** |
| **Name of Parent** |
| **Date** |
| **Agreed Review Date** |