**

Individual Healthcare Plan

For pupils with medical conditions at school

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| --- | --- |
| Date form completed |  |
| Date for review |  |
| Copies held by |  |
| 1. **Pupil Information**
 |
| Name | Class Teacher |
| Date of Birth | Male Female  |
| Member of staff responsible for home-school communication |
| 1. **Contact Information**
 |
| Pupils address |  |
| Family contact 1NameTelephoneMobileRelationship  | Family contact 2NameTelephoneMobileRelationship |
| GP NameAddressTelephone | Specialist ContactNameTelephone |
| 1. **Details of pupils medical condition(s)**
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| Signs and symptoms of medical condition: |
| Triggers that make the condition worse: |
| 1. **Routine healthcare requirements**

(for example, dietary, therapy, nursing needs or before physical activity) |
| 1. **What to do in an emergency**
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| 1. **Regular medication taken during school hours**

(including name, dose and time of administration) |
| 1. **Members of staff trained to administer medications for this pupil**
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| **Home/School Agreement****Parental and pupil agreement**I agree that the medical information contained in this plan may be shared with individuals involved in my/my child’s care and education (this includes emergency services)I understand that I must notify the school of any changes in writing. | Signed: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_PupilSigned: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_Parent/Carer |
| **Healthcare professional agreement**I agree that the information is accurate and up to date. | Signed: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ |
| **Head teacher agreement** |
| I agree that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will receive the above listed medication at the listed time. This arrangement will continue until the school is instructed otherwise by the named parent/carer in writing.Signed : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |