# Arbury_LogoIndividual Healthcare Plan – 2022/23

The following form must be completed where parents/carers have indicated that their child has an on-going medical condition. This plan must be reviewed at the start of each academic year.

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| --- | --- | --- | --- | --- |
| Child’s name |  | | | |
| Class |  | | | |
| Date of birth |  |  |  |  |
| Child’s address |  | | | |
| Medical diagnosis or condition |  | | | |
| Date |  |  |  |  |
| Review date | By September 2023 | | | |
| **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. |  | | | |

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, dose, 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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* 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 to my child’s medical needs.
* I understand that I will need to review this form annually.

Signature(s) Date

**------------------------------- School Section – Please do not fill in this part----------------------------------**

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

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Plan developed with

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Who is responsible for providing support in school

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Staff training needed/undertaken – who, what, when

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Form copied to

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| --- |
| School Individual Health care Plan File / Child’s Individual Record / Class Teaching file |

Completion Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_