

**Individual Healthcare Plan**

|  |  |
| --- | --- |
| **Personal Details** |  |
| Child’s full name |  |
| Form group |  |
| Date of birth |  |
| Medical diagnosis |  |
| Give as much detail as you can about their medical needsEg/ Symptoms, triggers, equipment, environmental issues |  |
| Emergency contact 1 |  |
| Relationship to child |  |
| Phone no(s) |  |
| Emergency contact 2 |  |
| Relationship to child |  |
| Phone no(s) |  |
|  |  |
| **Clinic/Hospital Contact** |  |
| Name |  |
| Phone No |  |
| **GP** |  |
| Name |  |
| Phone No |  |
|  |  |
| **Emergency care** |  |
| Treatment |  |
| Medicine to be used (must be provided from home) |  |
| Any further action to be taken in an emergency |  |
| **Routine care** |  |
| Daily care requirements |  |
| Support for educational, social or emotional needs |  |
| Any extra information needed for school trips? |  |
|  |  |
| **Extra information** |  |
| Are they immuno-compromised? | Yes/No |
| Are they receiving treatment for cancer? | Yes/No |
| Are they pregnant? | Yes/No |
|  |  |
| **Parental signature** |  |
| **Date** |  |