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**INDIVIDUAL HEALTHCARE PLAN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child’s name |  | | | |
| Year Group |  | | | |
| Date of birth |  |  |  |  |
| Child’s address |  | | | |
| Medical diagnosis or condition |  | | | |
| Date |  |  |  |  |
| Reviewed Yearly or as and when there are changes |  |  |  |  |
| **Family Contact Information** |  | | | |
| Name |  | | | |
| Relationship to child |  | | | |
| Phone no. (work) |  | | | |
| (home) |  | | | |
| (mobile) |  | | | |
|  | | | | |
| Name |  | | | |
| Relationship to child |  | | | |
| Phone no. (work) |  | | | |
| (home) |  | | | |
| (mobile) |  | | | |
|  |  | | | |
| **Doctor Contact** |  | | | |
| Practice Name |  | | | |
| Phone no. |  | | | |
|  |  | | | |
| **Clinic/Hospital Contact** |  | | | |
| Name |  | | | |
| Phone no. |  | | | |

HEALTH QUESTIONNAIRE

Has your child ever suffered any of the following conditions (please tick all that apply):

Diabetes

Chest Pains

Family History of Heart Disease

Muscular/Joint problems

Asthma or other respiratory problems

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Migraine/Dizziness

Recent Surgeries

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Any sustained injuries/illnesses

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Epilepsy

Difficulty with any form of physical exercise

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Currently taking any medication

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Severe allergic reaction

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Hearing

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Sight

Other

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|  |
| --- |
| If you ticked any of the above, please give details of the condition below: |

Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc. Please add extra information on a separate sheet if necessary.

|  |
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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 (please outline)

|  |
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|  |

Describe what constitutes an emergency, and the action to take if this occurs

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|  |

I give consent for Lingfield staff to administer the following in appropriate doses:

Paracetamol

* Prior to administration a check will always be carried out into the last recorded dose
* Paracetamol cannot be administered if taken within the last **4 hours.**
* Parents will be notified via email that paracetamol has been administered

Parent/Guardian signature …………………………………………. Date ………………………….