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INDIVIDUAL HEALTHCARE PLAN

Child's name				
Form				
Date of birth				
Child's address				
Medical diagnosis or condition				
Date				
Review date				
Family Contact Information				
Name				
Relationship to child				
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.				

HEALTH QUESTIONNAIRE

Has your child ever suffered from any of the following conditions? *(tick all that apply)*

- ☐ Diabetes
- ☐ Chest Pains
- ☐ Family History of Heart Disease
- ☐ Muscular/Joint problems
- ☐ Asthma or other Respiratory Problems
- ☐ Migraine/Dizziness
- ☐ Recent Surgeries
- ☐ Any sustained injuries/illnesses
- ☐ Epilepsy
- ☐ Difficulty with any form of physical exercise
- ☐ Currently taking any medication
- ☐ Severe allergic reaction
- ☐ Other

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

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision:

Daily care requirements:

Specific support for the pupil's educational, social and emotional needs (*please outline*)

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

I give consent for Lingfield staff to administer the following medication 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 …………………