04 Health procedures

**04.02l Health care plan**

*Please note that this form must be used alongside the individual child’s registration form which contains emergency parental contact and other personal details.*

|  |  |
| --- | --- |
| **Name of Child** |  |
| **Date of Birth** |  |
| **Child’s address** |  |
| **Contact information for family or main carers** |
| **1.Name** |  |
| **Relationship to child** |  |
| **Contact numbers** |  |
| **2. Name** |  |
| **Relationship to child** |  |
| **Contact numbers** |  |
| **Medical diagnosis, condition or allergy** |
| **Clinic or Hospital contact** |
| Name |  |
| Phone no. |  |
| **GP/Doctor** |
| Name |  |
| Phone No. |  |

|  |
| --- |
| **Describe medical needs and give details of symptoms** |
|  |
| **Risk assessment completed?****If no, please state why?****If yes please include details here****Date completed:** |
| **Daily care requirements e.g. before meals/going outdoors (what does this look like in practice)** |
|  |
| **Specific Support for the child’s educational, social and emotional needs** |
|  |
| **Arrangements for setting trips and outings** |
|  |
| **Describe what constitutes an emergency for the child and what actions are to be taken if this occurs** |
| **Name/s of staff responsible for an emergency situation with this child** |
| **Additional staff training needed / undertaken – Who, what, when** |
| **Has a One Plan been implemented Yes / No** |
| **If you have not started a One Plan please give reason…** |

**Parent/carer and person completing this form must sign below to indicate that the information in this plan is accurate and the parent/carer agrees for any relevant procedures to be carried out**

|  |  |  |
| --- | --- | --- |
| Parent’s name | Signature | Date |
| Key person’s name | Signature | Date |
| Setting Manager’s name | Signature | Date |

For children requiring lifesaving or invasive medication and/or care, for example, rectal diazepam, adrenaline injectors, Epipens, Anapens, JextPens, maintaining breathing apparatus, changing colostomy or feeding tubes, approval must be received from the child’s GP/consultant, as follows:

I have read the information in this Individual Health Plan and have found it to be accurate.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of GP/consultant: |  | Date: |  |
| Signature: |  |

**Review completed (at least every six months)**

|  |  |  |
| --- | --- | --- |
| Parent’s name | Signature | Date |
| Key person’s name | Signature | Date |
| Setting manager’s name | Signature | Date |

**Copies circulated to:**

Parents

Child’s personal records (in medical file)

GP/Consultant – if required