

**6.8 Individual Health Plan**

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

Date completed: Review date:

**Child’s details:**

Full name: Date of birth: Address:

Allergies:

Medical condition/diagnosis

Medical needs and symptoms:

Daily care requirements:

Medication details (inc. expiry date/disposal)

Storage of medication:

Procedure for administering medication:

Staff Training Needed YES/NO (If Yes, please give details)

Date training undertaken

Names of staff trained to carry out health plan procedures and administer medication:

List of any activities that may exacerbate the condition/illness/allergy

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Risk | Risk level | Action taken |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Other information:

Date risk assessment completed:

Risk assessment details:

Describe what constitutes an emergency for the child, what procedures will be taken if this occurs and the names of staff responsible for an emergency situation with the child:

Would medication be needed to be taken on an outing? e.g. inhaler YES/NO (If YES, please give details)

**Child’s main carer(s)**

1. Name: Relationship to child: Contact number(s):

2. Name: Relationship to child:

Contact number(s):

**General Practitioner’s details:**

Name: Contact number: Address:

**Clinic of Hospital details (if app):**

Name: Contact number: Address:

Measures to be taken in a case of emergency

**Declaration**

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

Name of parent: Date: Signature:

Name of key person: Date:

Signature:

Name of manager: Date:

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, you must receive approval 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:

**To be reviewed at least every six months, or as and when needed. Copied to parents and child’s personal file (with registration form)**