**6.7 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: |  |
| Names of staff trained to carry out health plan procedures and administer medication: |
|  |
| 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: |
|  |

**Child’s main carer(s)**

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

**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 life saving 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)**