Individual Healthcare Plan

For Students with a Medical Condition

Student's Name	
Year/Guild	
Date of Birth	
Students Primary Address	
Medical Diagnosis or Condition	
Known Allergies	
Date Healthcare Plan Completed	

Family Contact Information

Name of Emergency Contact 1		
Contacts Phone Numbers	*Home:*	*Mobile:*
Relationship to student		

Name of Emergency Contact 2		
Contacts Phone Numbers	*Home:*	*Mobile:*
Relationship to student		

G.P's Contact Details

GP Name	
Phone number	
Email Address	
First Line of Address	

Health Professionals Contact Details

Name:	
Role:	
Phone Number:	
Email Address	
First Line of Address	

Additional Contacts Details:

Condition Information *Details of child's symptoms, triggers, signs, treatments etc*

Condition 1*:* _____

_____

Symptoms: _____

_____

_____

Triggers/things that make it worse:

_____

What action must be taken? Treatment, medication, therapeutic treatment, care and support:

_____

_____

_____

Condition 2*:* _____

_____

Symptoms: _____

_____

_____

Triggers/things that make it worse:

_____

What action must be taken? Treatment, medication, therapeutic treatment, care and support:

_____

_____

_____

Care & Support

Routine/Daily Medicine(s) at Home:

Name of Medicine:	*Dose:*	*Time to be given:*

Emergency Medications to be given at School: *what drug, when to give, dose & method of administration*

Name of Medicine:	*Dose:*	*Time to be given:*	*Method:*

Are there any physical restrictions caused by the medical condition(s)?
i.e physical activity/triggers in school

Specific support or equipment required in school *(for medical, learning, emotional needs)*

Activities that require special precautions, management and risk assessment considerations

Arrangement for school trips/excursions

Additional information

This plan has been agreed by:

Staff Members:

Name:	*Role:*

Parent/Guardian:

Name:	Signature:
Relationship:	Contact number:

Student:

Name:	Signature: