FURROWFIELD SCHOOL / CROSSFIELD HOUSE

INDIVIDUAL HEALTHCARE PLAN

YOUNG PERSON'S DETAILS:

Name: ……………………………………………………………… …………………………… DoB: ……………………………………
Address: ……….
……….Postcode: ……………………………

PARENT'S/CARER'S DETAILS:

Name: …………………………………………………………… Relationship to Child: ………………………………………
Tel. No.: ……………………………………………………… Parental Responsibility? Yes/No

Contact 2: ………………………………………… Relationship: …………………… Tel. No.: ……………………………

PROFESSIONAL CONTACTS:

GP Name: ………………………………………………………………………… Tel No.: ……………………………………………

Looked After Child / Child Protection / Child in Need / Team Around The Family

Any Other Professionals Involved – CYPS, Consultant, Therapist, Social Worker, etc:

Name: ……………………………………………………… Role: ………………………………………………………………

Contact Details: ……

Name: ……………………………………………………… Role: ………………………………………………………………

Contact Details: ……

SCHOOL SUPPORT:

Key Contact responsible for providing support in school: ……………………………………………………………

Residential Status: Full-time/ Part-time Mon Tues Wed Thurs (please circle)

DIAGNOSED MEDICAL CONDITION 1: ……………………………………………………………………………………………………

Date: ……………………………………………………………… Review Date: …………………………………………………….

Name of Medication 1: ……………………………………………………………………….. Self-Administered?: Yes/No

Dosage and Frequency: ……………………………………………………………………………………………………….

Please advise any side effects: ……………………………………………………………………………………………………

DIAGNOSED MEDICAL CONDITION 2: ……………………………………………………………………………………………………

Date: ……………………………………………………………… Review Date: …………………………………………………….

Name of Medication 2: ……………………………………………………………………….. Self-Administered?: Yes/No

Dosage and Frequency: ……………………………………………………………………………………………………….

Please advise any side effects: …………………………………………………………………………………………………….

DIAGNOSED MEDICAL CONDITION 3: ……………………………………………………………………………………………………

Date: ……………………………………………………………… Review Date: …………………………………………………….

Name of Medication 3: ……………………………………………………………………….. Self-Administered?: Yes/No

Dosage and Frequency: ……………………………………………………………………………………………………….

Please advise any side effects: …………………………………………………………………………………………………….

MEDICAL CONDITIONS/NEEDS:

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues, etc.

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Daily care requirements:

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Specific support for the pupil's educational, social and emotional needs.

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Arrangements for school visits/trips, etc.

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Other information:

……

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

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Who is responsible in an emergency (state if different for off-site activities)
………
Plan developed with: ……..

Staff training needed/undertaken – who, what, when:
………
………

Parent/Carer – Please sign if you give permission for staff to administer prescribed medication to your child whilst in residences/school. This arrangement will continue until the end date of the medication or we are instructed otherwise by the GP, parents or carers.

Signed: …………………………………………………………………………… Date: ……………………………………………………………

Nominated member of staff who will administer medication: …………………………………………………………..

Headteacher to sign to authorise nominated staff to administer medication in school
Signed: …………………………………………………………………………… Date: …………………………………………………..……

Care Plan Review
Signed: ……………………………………………………………………………. Date: ……………………………………………….……

Form copied to: ……