

## 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: \_\_\_\_\_

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): \_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_

**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)**