

HEALTH CARE PLAN FOR A CHILD/YOUNG PERSON WITH MEDICAL NEEDS

Name of establishment	
Child's name	
Group/class/form	
Date of birth	/ /
Child's address	
Medical diagnosis or condition	
Date	/ /
Review date	/ /

Contact Information**Contact 1:**

Name	
Relationship	
Phone no. (work)	
(home)	
(mobile)	

Contact 2:

Name	
Relationship	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

General Practitioner (G.P.)

Name	
Phone no.	

Appendix 2

Describe medical needs and give details of child's symptoms

Daily care requirements (e.g. before sport/at lunchtime)

Describe what constitutes an emergency for the child and the action to take if this occurs

Appendix 2

Follow up care

--

Who is responsible in an emergency (*state if different for off-site activities*)

--

I confirm that I have agreed this Healthcare Plan and undertake to keep the establishment updated on any changes.

Name of parent/carer
Signature of parent/carer
Date
Signature of Representative

A completed copy of this form will be given to the parent/carer and one will be retained by the establishment.

Completed copy given to parent/carer on _____

By _____

Parental/Carer Request to administer medicine

The establishment will not give your child medicine unless you complete and sign this form .

Name of establishment	
Name of child	
Date of birth	/ /
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine (as described on the container)	
Date dispensed	/ /
Expiry date	/ /
Agreed review date	
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the establishment/setting needs to know about?	
Self administration	
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
The medication will be delivered by:	
The medication will be handed to:	

I accept that this is a service that the establishment is not obliged to undertake.

I understand that I must notify any changes in writing.

Date _____ Signature of Parent/Carer _____

Parental/Carer agreement to administer medicine

The establishment will not give your child medicine unless you complete and sign this form.

Name of establishment/setting	
Date	/ /
Child's name	
Group/class/form	
Name and strength of medicine	
Expiry date	/ /
How much to give (<i>i.e. dose to be given</i>)	
When to be given	
Any other instructions	
Number of tablets/quantity to be given to establishment/setting	
Note: Medicines must be in the original container as dispensed by the pharmacy	
Daytime phone no. of parent/carers contact	
Name and phone no. of GP	
Agreed review date	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to staff administering medicine in accordance with the policy. I will inform the establishment immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent/carers signature _____

Print name _____

Date _____

If more than one medicine is to be given a separate form should be completed for each one

Manager / Head teacher agreement to administer medicine

Name of establishment/setting	
Date	/ /
Child's name	
Group/class/form	
Medication, quantity and time to be given.	
Name of person to give/supervise the taking of the medicine.	

This arrangement will continue until (either end date of course of medicine or until instructed by parent/ carer)_____

Date _____

Signed _____

Manager/Headteacher

Record of medicine administered to an individual child

Name of establishment/setting	
Name of child	
Date medicine provided by parent	/ /
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	/ /
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff and signature			
Name of witness and signature			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff and signature			
Name of witness and signature			

Appendix 2

Record of medicine administered to an individual child (Continued)

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff and signature			
Name of witness and signature			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff and signature			
Name of witness and signature			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff and signature			
Name of witness and signature			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff and signature			
Name of witness and signature			

Request for child to carry his/her own medicine

This form must be completed by parent/carer

If staff have any concerns discuss this request with healthcare professionals

Name of establishment/setting

--

Child's name

--

Group/class/form

--

Address

--

Name of medicine

--

Procedures to be taken in an
Emergency

--

Contact Information

Name

--

Daytime phone no.

--

Relationship to child

--

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signed _____

Date _____

Staff training record – administration of medicines

Name of establishment/setting	
Name	
Type of training received	
Date of training completed	/ /
Training provided by	
Profession and title	

I confirm that (name of staff) _____ has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated (please state how often)_____.

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

1. Your telephone number

2. Give your location as follows
(insert address)

3. State that the postcode is

4. Give exact location in the establishment /setting

5. Give your name

6. Give name of child and a brief description of child's symptoms

7. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to

Speak clearly and slowly and be ready to repeat information if asked

Put a completed copy of this form by the telephone