A logo for a pre-school

Description automatically generated

04 Health procedures

**04.2a Health care plan**

*Please note that this form must be used alongside the individual child’s registration form which contains emergency parental contact and other personal details.*

|  |  |  |
| --- | --- | --- |
| **Name of Child** | |  |
| **Date of Birth** | |  |
| **Child’s address** | |  |
| **Contact information for family or main carers** | | |
| **1.Name** | |  |
| **Relationship to child** | |  |
| **Contact numbers** | |  |
| **2. Name** | |  |
| **Relationship to child** | |  |
| **Contact numbers** | |  |
| **Medical diagnosis, condition or allergy** | | |
| **Clinic or Hospital contact** | | |
| Name |  | |
| Phone no. |  | |
| **GP/Doctor** | | |
| Name |  | |
| Phone No. |  | |

|  |
| --- |
| **Describe medical needs and give details of symptoms** |
|  |
| **Risk assessment completed?**  **If no, please state why?**  **If yes please include details here**  **Date completed:** |
| **Daily care requirements e.g. before meals/going outdoors** |
|  |
| **Describe what constitutes an emergency for the child and what actions are to be taken if this occurs** |
| **Name/s of staff responsible for an emergency situation with this child** |

**Parent/carer and person completing this form must sign below to indicate that the information in this plan is accurate and the parent/carer agrees for any relevant procedures to be carried out**

|  |  |  |
| --- | --- | --- |
| Parent’s name | Signature | Date |
| Key person’s name | Signature | Date |
| Setting Manager’s name | Signature | Date |

For children requiring lifesaving or invasive medication and/or care, for example, rectal diazepam, adrenaline injectors, Epipens, Anapens, JextPens, maintaining breathing apparatus, changing colostomy or feeding tubes, approval must be received 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: |  | | |

**Review completed (at least every six months)**

|  |  |  |
| --- | --- | --- |
| Parent’s name | Signature | Date |
| Key person’s name | Signature | Date |
| Setting manager’s name | Signature | Date |

**Copies circulated to:**

Parents

Child’s personal records (with registration form)

GP/Consultant – if required