****

**School Individual Healthcare Plan for a Pupil with Medical Needs**

|  |  |
| --- | --- |
| **Details of Child and Condition** | |
| **Name of child:** | ***Add photo here*** |
| **Date of birth:** |
| **Class/Form:** |
| **Medical Diagnosis/Condition:** |
| **Triggers:** |
| **Signs/Symptoms** | |
| **Treatments:** | |
| **Has the Parental Consent Form been completed?  *Yes/No***  ***(Medication cannot be administered without parental* *approval)*** | |
| **Date:** | **Review Date:** |
| **Medication Needs of Child** | |
| **Medication:** | |
| **Dose:** | |
| **Specify if any other treatments are required:** | |
| **Can the pupil self-manage his/her medication? *Yes/No* If *Yes*, specify the arrangements in place to monitor this:**    **Indicate the level of support needed, including in emergencies: *(some children will be able to take responsibility for their own health needs)*** | |
| **Known side-effects of medication:** | |
| **Storage requirements:**  CHILD’s medication is to be stored in the medication cabinet.  AMBLE SITE - The medication cabinet is secure and locked. It is located in the reception office. | |
| **What facilities and equipment are required? *(such as changing table or hoist)*** | |
| **What testing is needed? *(such as blood glucose levels):*** | |
| **Is access to food and drink necessary? *(where used to manage the condition):  Yes/No***  **Describe what food and drink needs to be accessed** | |
| **Identify any dietary requirements:** | |
| **Identify any environmental considerations *(such as crowded corridors, travel time between lessons):***  CHILD requires a quiet space with limited/no distractions when being supported to take any medication. | |
| **Action to be taken in an emergency *(If one exists, attach an emergency healthcare plan prepared by the child’s lead clinician):*** | |
| **Staff Providing Support** | |
| **Give the names of staff members providing support *(State if different for off-site activities):***   * Two Available members of staff will administer medication in school. (Staff Rota in place) * All staff have completed the ‘safe administration of medication training’. Training is updated annually. * Any member of staff who has not completed the allocated training will not administer medication. | |
| **Describe what this role entails:** | |
| **Have members of staff received training?  *Yes/No***  **(*details of training should be recorded on the Individual Staff Training Record, Appendix 4)*** | |
| **Where the parent or child have raised confidentiality issues, specify the designated individuals who are to be entrusted with information about the child’s condition:**   * SLT * Medication co-ordinator * Teaching/support staff | |
| **Detail the contingency arrangements in the event that members of staff are absent:**  There is sufficient staff trained in the safe administration of medication in school/resi to cover staff absences | |
| **Indicate the persons (or groups of staff) in school who need to be aware of the child’s condition and the support required:**   * SLT * Medication co-ordinator * Teaching/support staff | |
| **Other Requirements** | |
| **Detail any specific support for the pupil’s educational, social and emotional needs**  ***(for example, how absences will be managed; requirements for extra time to complete exams; use of rest periods; additional support in catching up with lessons or counselling sessions)*** | |
| **Emergency Contacts** | |
| ***Family Contact 1***  **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Telephone**  ***Work*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Home*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Mobile*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | ***Family Contact 1***  **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Telephone**  ***Work*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Home*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Mobile*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ***Clinic or Hospital Contact***  **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Telephone:**  ***Work*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | ***GP***  **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Telephone:**  ***Work*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Signatures** | |
| ***Signed***  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***(Headteacher)*** | ***Signed***  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***(Medication Coordinator)*** |