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

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| **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.
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| **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
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| **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
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| **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)*** |