



Individual Healthcare Plan

Name of setting	Shalfleet Little Explorers
Child's name	
Class	
Date of birth	
Child's address	
Medical condition/diagnosis	
Date of completion	
Review date	

Family Contact Information

Name	
Relationship to child	
Phone number (home)	
Phone number (mobile)	
Phone number (work)	
Name	
Relationship to child	
Phone number (home)	
Phone number (mobile)	
Phone number (work)	

Clinic/Hospital Contact

Name	
Hospital/Clinic role	
Phone number	

Name

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Hospital/Clinic role

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Phone number

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G.P.

Name

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GP surgery

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Number

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Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.

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Name of medication, dose, method of administration, when to be taken, side effects, administered by self/with supervision or by adult etc.

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Daily care requirements

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Specific support for child's educational, social, and emotional needs

Arrangements for school visits/trips

Other information

Describe what constitutes as an emergency and what action to take if this occurs

What staff member/s are responsible for the child at the setting (to be completed by the setting)

Plan developed with

Staff training undertaken; who, what, when (to be completed by setting)

Form copied to (to be completed by setting)

Parent signature: _____ Parent name: _____

Date: _____

Practitioner signature: _____ Practitioner name _____

Date: _____