



EDGBARROW SCHOOL INDIVIDUAL HEALTHCARE PLAN

Photo

To be completed by the parent/carer and pupil with guidance from your child's
Healthcare Professional (eg. GP, Specialist, Doctor or Nurse)

Student Information

Student Name			
Tutor Group			
Date of Birth		Gender	Male / Female
Home Address			

Family Contact Information

Parent/Carer Name		Parent/Carer Name	
Home Tel.		Home Tel.	
Mobile Tel.		Mobile Tel.	
Work Tel.		Work Tel.	

Medical Practice Details

GP Name:		Specialist Name:	
Surgery Name:		Hospital/Clinic Name:	
Surgery Address:		Hospital/Clinic Address:	
Surgery Tel.		Hospital/Clinic Tel.	

Medical Condition

Medical diagnosis or condition relating to Individual Healthcare Plan			
Other diagnosed medical conditions including SEND			
Signed Parent/Carer:			Date:

To be completed by the school

Date of Plan Complete:	Review Date:
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TO BE COMPLETED BY THE PARENT/CARER AND STUDENT WITH GUIDANCE FROM YOUR CHILD'S HEALTHCARE PROFESSIONAL (E.G. GP, SPECIALIST, DOCTOR OR NURSE)

Describe medical needs and give details of the child's symptoms

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

Regular Medication Taken

Medication Name:	Time:	Dose:	Side Effects:

If Medication is required in school please complete a Parent/Carer Medicine Consent Form

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

Emergency Medication Taken

Medication Name:	Dose:	Side Effects:

Follow up care

Parental and student agreement

I agree that the information contained in this plan may be shared with individuals involved with my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing.

Signed (student)		Date	
Print Name			
Signed (parent/carer)		Date	
Print Name			

Head of Pastoral agreement

We agree to provide the support required as set out in the Healthcare Plan

Signed		Date	
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