A picture containing diagram

Description automatically generated

**Pupil Health Care Plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of student: |  | Group/class | |  |
|  | | | | |
| Date of birth: |  | Date form submitted: | |  |
|  | | | | |
| Contact information: Please complete with the details of emergency contacts for pupil | | | | |
| Name  Address  Daytime number  Evening number |  | |  | |
|  | |  | |
|  | |  | |
|  | |  | |
| Relationship |  | |  | |

|  |  |  |
| --- | --- | --- |
| Any additional information regarding emergency contacts: | | |
| Medical contact information: Please complete with the details of medical contacts | | |
| Contact | Surgery/GP | Clinic/hospital contact |
| Name  Address  Phone number |  |  |
|  |  |
|  | Hospital number/ |

**Allergies**

|  |  |  |
| --- | --- | --- |
| Please complete the below of any allergies that your child has | | |
| Skin Allergies | Food Allergies | Medication Allergies |
|  | Yes No  Lactose  Dairy  Gluten  Nut |  |
| Please complete the box below of any other known allergies or further information required | | |
|  | | |

|  |  |
| --- | --- |
| Please complete with details of healthcare professionals | |
| Paediatrician |  |
| Nursing Team |  |
| Physiotherapist |  |
| Occupational Therapist |  |
| Dietitian |  |
| MIC-KEY Button PEG Tube Jejunal Tube  Yes No Yes No Yes No | |

**Medical condition(s)/illness**

|  |
| --- |
| Diagnosed medical condition |
|  |

|  |
| --- |
| Diagnosed Epilepsy |
|  |

|  |
| --- |
| Any additional information (i.e. suffers with sickness, loose bowel due to medical condition) |
|  |

|  |
| --- |
| Special precautions/other instructions |
|  |

|  |
| --- |
| Any specific information required to accompany child to hospital/emergency services |
|  |

**Medications**

|  |
| --- |
| Medication taken at home |
|  |

|  |
| --- |
| Medication taken in school |
|  |

|  |
| --- |
| Route of medication administration (i.e. orally, enteral) |
|  |

|  |
| --- |
| Any side effects to medication taken in school that we need to be aware of |
|  |

**Care Plans**

|  |  |  |  |
| --- | --- | --- | --- |
| Care plans | Yes | No | Additional information |
| Healthcare plan |  |  |  |
| Feeding plan |  |  |  |
| Epilepsy plan |  |  |  |
| Asthma plan |  |  |  |
| Oxygen plan |  |  |  |
| Suctioning plan |  |  |  |
| Respect plan |  |  |  |
| Any additional plan |  |  |  |
| Shunt |  |  |  |

**I agree that all the information in this document is correct to the best of my knowledge**

**Date:**

**Parent/carer**

**Print full name: Signature:**

**Health Care Lead**

**Print full name: Signature:**

**Agreed review date:**

**Signature: Print:**

**Signature: Print:**