

**Pupil Health Care Plan**

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| --- | --- | --- | --- |
| Name of student: |  | Group/class |  |
|  |
| Date of birth: |  | Date form submitted: |  |
|  |
| Contact information: Please complete with the details of emergency contacts for pupil |
| NameAddressDaytime numberEvening 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 |
| NameAddressPhone 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) |
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|  |
| --- |
| Special precautions/other instructions  |
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| --- |
| Any specific information required to accompany child to hospital/emergency services  |
|  |

**Medications**

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| --- |
| Medication taken at home  |
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|  |
| --- |
| Medication taken in school  |
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| --- |
| 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:**