



6.8 Individual Health Plan

This form must be used alongside the individual child's registration form which contains emergency parental contact and other personal details.

Date completed: _____ Review date: _____

Child's details:

Full name: _____ Date of birth: _____

Address: _____

Allergies: _____

Medical condition/diagnosis _____

Medical needs and symptoms: _____

Daily care requirements: _____

Medication details (inc. expiry date/disposal) _____

Storage of medication: _____

Procedure for administering medication: _____

Names of staff trained to carry out health plan procedures and administer medication: _____

Other information: _____

Date risk assessment completed: _____

Risk assessment details: _____

Describe what constitutes an emergency for the child, what procedures will be taken if this occurs and the names of staff responsible for an emergency situation with the child:

Child's main carer(s)

1. Name: _____ Relationship to child: _____

Contact number(s): _____

2. Name: _____ Relationship to _____

[Type here]



child: _____

Contact number(s): _____

General Practitioner's details:

Name: _____

Contact number: _____

Address: _____

Clinic of Hospital details (if app):

Name: _____

Contact number: _____

Address: _____

Declaration

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

Name of parent: _____

Date: _____

Signature: _____

Name of key
person: _____

Date: _____

Signature: _____

Name of manager: _____

Date: _____

Signature: _____

Date: _____

For children requiring life saving or invasive medication and/or care, for example, rectal diazepam, adrenaline injectors, Epipens, Anapens, JextPens, maintaining breathing apparatus, changing colostomy or feeding tubes, you must receive approval from the child's GP/consultant, as follows:

I have read the information in this Individual Health Plan and have found it to be accurate.

Name of
GP/consultant: _____

Date: _____

Signature: _____

To be reviewed at least every six months, or as and when needed.

[Type here]



6 Month Review (1)

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

Name of parent: _____ Date: _____

Signature: _____

Name of key person: _____ Date: _____

Signature: _____

Name of manager: _____ Date: _____

Signature: _____

Date: _____

6 Month Review (2)

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

Name of parent: _____ Date: _____

Signature: _____

Name of key person: _____ Date: _____

Signature: _____

Name of manager: _____ Date: _____

Signature: _____

Date: _____

[Type here]



6 Month Review (3)

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

Name of parent: _____ Date: _____

Signature: _____

Name of key person: _____ Date: _____

Signature: _____

Name of manager: _____ Date: _____

Signature: _____

Date: _____

6 Month Review (4)

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

Name of parent: _____ Date: _____

Signature: _____

Name of key person: _____ Date: _____

Signature: _____

Name of manager: _____ Date: _____

Signature: _____

Date: _____

[Type here]