6.8 Individual Health Plan

This policy was adopted by	East Leake Pre-School Playgroup		*(name of provider)*
On	17/01/2018		*(date)*
Date to be reviewed	January 2018		*(date)*
Signed on behalf of the provider			
Name of signatory	Sara Last	Debbie Porter	Tamsin Wisher
Role of signatory (e.g. chair, director or owner)	Manager	Co – Chair	Co – Chair

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 child: _____

Contact number(s): _____

General Practitioner's details:

Name: _____ Contact number: _____

Address: _____

_____

Clinic / Hospital details (if applicable):

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.

Copied to parents and child's personal file (with registration form)