

TIBSHELF COMMUNITY SCHOOL

INDIVIDUAL HEALTHCARE PLAN



ESSENTIAL INFORMATION CONCERNING THIS CHILD / YOUNG PERSON'S HEALTH NEEDS

	Name	Contact details
Specialist nurse (if applicable):		
Key worker:		
Consultant paediatrician (if applicable):		
GP:		
Link person in education:		
Class teacher:		
Health visitor/ school nurse:		
SEN co-ordinator:		
Other relevant teaching staff:		
Other relevant non-teaching staff:		
Head teacher:		
Person with overall responsibility for implementing plan:		
Any provider of alternate provision:		

This child/ young person has the following medical condition(s)	
That requires the following treatment	

Medical condition	Drug	Dose	When	How is it administered?

Does treatment of the medical condition affect behaviour or concentration?	
Are there any side effects of the medication?	
Is there any ongoing treatment that is not being administered in school? What are the side effects?	

ROUTINE MONITORING (IF APPLICABLE)

Some medical conditions will require monitoring to help manage the child/ young person's condition.

What monitoring is required?	
When does it need to be done?	
Does it need any equipment?	
How is it done?	
Is there a target? If so, what is the target?	

EMERGENCY SITUATIONS

An emergency situation occurs whenever a child/ young person needs urgent treatment to deal with their condition.

What is considered an emergency situation?	
What are the symptoms?	
What are the triggers?	
What action must be taken?	
Are there any follow up actions (eg tests or rest) that are required?	

IMPACT ON CHILD'S LEARNING

How does the child's medical condition effect learning? i.e. memory, processing speed, coordination etc	
Does the child require any further assessment of their learning?	

PHYSICAL ACTIVITY	
Are there any physical restrictions caused by the medical condition(s)?	
Is any extra care needed for physical activity?	
Actions before exercise	
Actions during exercise	
Actions after exercise	

TRIPS AND ACTIVITIES AWAY FROM SCHOOL	
What care needs to take place?	
When does it need to take place?	
If needed, is there somewhere for care to take place?	
Who will look after medicine and equipment?	
Who outside of the school needs to be informed?	
Who will take overall responsibility for the child/young person on the trip?	

SCHOOL ENVIRONMENT

Can the school environment affect the child's medical condition?	
How does the school environment affect the child's medical condition?	
What changes can the school make to deal with these issues?	
Location of school medical room	

EDUCATIONAL, SOCIAL & EMOTIONAL NEEDS

Pupils with medical conditions may have to attend clinic appointments to review their condition. These appointments may require a full day's absence and should not count towards a child's attendance record.

Is the child/young person likely to need time off because of their condition?	
What is the process for catching up on missed work caused by absences?	
Does this child require extra time for keeping up with work?	
Does this child require any additional support in lessons? if so what?	
Is there a situation where the child/young person will need to leave the classroom?	
Does this child require rest periods?	
Does this child require any emotional support?	
Does this child have a 'buddy' e.g. help carrying bags to and from lessons?	

REQUEST FOR CHILD TO CARRY OUT THEIR OWN MEDICINE

This form must be completed by parents/carers/student over 16 years (delete as appropriate)

If staff have any concerns discuss this request with healthcare professionals

Name of School/Setting	Tibshelf Community School
Childs name	
Date of birth	
Form	
Address	
Name of Medicines	
Procedure to be taken in an emergency	
Contact Information	
Name	
Daytime telephone number	
Mobile Number	
Relationship to child	

I would like my son/daughter to keep his/her medicine on him/her for use as necessary

Signed _____

Date _____

If more than one medicine is to be given a separate form should be completed for each one.

PARENTAL CONSENT FOR SCHOOLS/SETTING TO ADMINISTER MEDICATION

Child's Name	
D.O.B	
Form/Year	
Name and Strength of Medication	
Dosage and Method	
Time to be given	
Special precautions	
Any further instructions	
Number of tablets/quantities received by school	
Start Date	End Date

NB. MEDICATION MUST BE IN THE ORIGINAL BOX/CONTAINER, AS DISPENSED BY THE PHARMACY WITH CLEAR INSTRUCTIONS ON HOW MUCH TO GIVE.

Are there any side effects that the school/Setting needs to know about?	
Self-Administration	YES NO
Procedures to take in emergency	
Telephone number of Parent/Carer	
Name and Phone number of G.P.	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school staff administering the medication in accordance with the school policy. I will inform the school immediately, in writing if there is any change in dosage of frequency of the medication or if the medication is stopped.

Parent's/Carer's signature _____ Date _____

Print Name _____

If more than one medication is to be given, a separate form should be completed for each.