

PLAN NUMBER:

HEALTH CARE PLAN FOR A PUPIL WITH MEDICAL NEEDS

Name:

Date of Birth:

Condition:

Class/Form:

Name of School

Date:

Review Date:

CONTACT INFORMATION

Family contact 1

Name:

Phone No. (work):
(home):

Relationship:

Family contact 2

Name:

Phone No. (work):
(home):

Relationship:

Clinic/Hospital contact

Name:

Phone No:

GP

Name:

Phone No:

Describe condition and give details of pupil's individual symptoms:

Daily care requirements: (eg. before sport, at lunchtime etc.)

Describe what constitutes an emergency for the pupil, and the action to take if this occurs:

Follow up care:

Who is responsible in an Emergency: (state if different for off site activities)

Form copied to:

NOTE:

Please be aware of the confidential nature of this information, be discreet and **DO** get permission from the parent or guardian prior to copying information or exhibiting photo's in medical rooms etc.

