



Individual Healthcare Plan

**General**

Photo of Pupil

**Name Of Pupil**  Date Of Birth

Name and Contact Details of Parent/Guardian

**GP Name:**

Surgery Address:

Surgery Phone No:

**Specialist Nurse/Doctor**

Name:

Hospital:

Phone No:

**I have discussed this care plan with a health representative from the school and am satisfied that it reflects my/my child’s health care needs in school.**

Signature of Parent/Guardian Date

Print Name

Health Care Plan Review Date:

**Pupil’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIAGNOSIS:**  *(To be added)*

**Health Care Needs In School**

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*(Healthcare needs can be added)*

**Response To Symptoms**

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**Emergency Action**

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• Contact parent regarding medical intervention

Health Care Plan Completed By: ­­­­­­­

Designation:

Date: