



Dear Parent,

#### DEVELOPING AN INDIVIDUAL HEALTHCARE PLAN FOR YOUR CHILD

Thank you for informing us of your child's medical condition. I enclose a copy of the school's policy for supporting pupils at school with medical conditions for your information.

A central requirement of the policy is for an individual healthcare plan to be prepared, setting out what support each pupil needs and how this will be provided. Individual healthcare plans are developed in partnership between the school, parents, pupils, and the relevant healthcare professional who can advise on your child's case. The aim is to ensure that we know how to support your child effectively and to provide clarity about what needs to be done, when and by whom. Although individual healthcare plans are likely to be helpful in the majority of cases, it is possible that not all children will require one. We will need to make decisions about how we can support your child should their medical condition impact on their ability to participate fully in school life, and the level of detail within plans will depend on the complexity of their condition and the degree of support needed.

It would be helpful if you could complete the attached individual healthcare plan template and return it, together with any relevant evidence. The school would be happy for you contact Julie Thomas on [Julie.thomas@steiner-south-devon.org](mailto:Julie.thomas@steiner-south-devon.org) by email or to speak by phone if this would be helpful.

South Devon Steiner School



## Form A: individual healthcare plan

Name of school/setting

Child's name

Class

Date of birth

Child's address

Medical diagnosis or condition

Date

Review date


### Family Contact Information

Name

Phone no. (work)

(home)

(mobile)

Name

Relationship to child

Phone no. (work)

(home)

(mobile)


### Clinic/Hospital Contact

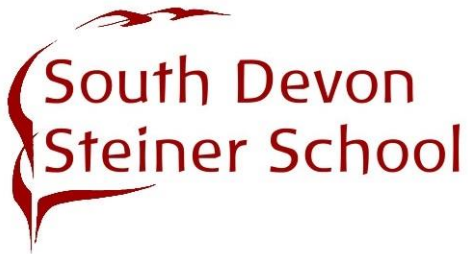
Name

Phone no.


### G.P.

Name

Phone no.

Who is responsible for providing support in school?

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision.

Daily care requirements.

Specific support for the pupil's educational, social and emotional needs.

Arrangements for school visits/trips etc.

Other information



Describe what constitutes an emergency, and the action to take if this occurs.

Who is responsible in an emergency (*state if different for off-site activities*)?

Plan developed with:

Staff training needed/undertaken – who, what, when?

Form copied to:



## Form B: parental agreement to administer medicine

The school will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Date for review to be initiated by:

Name of school/setting

Name of child

Date of birth

Class

Medical condition or illness


### Medicine

Name/type of medicine  
*(as described on the container)*

Expiry date

Dosage and method

Timing

Special precautions/other instructions

Are there any side effects that the school/setting needs to know about?

Self-administration – y/n

Procedures to take in an emergency


**NB: Medicines must be in the original container as dispensed by the pharmacy**

### Contact Details

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to:

[agreed member of staff]



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

Signature(s) \_\_\_\_\_

Date \_\_\_\_\_



## Form C: record of medicine administered to an individual child

Name of school/setting	
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

Staff signature \_\_\_\_\_

Signature of parent \_\_\_\_\_

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

**C: Record of medicine administered to an individual child (Continued)**

Date

Time given

Dose given

Name of member of staff

Staff initials


Date

Time given

Dose given

Name of member of staff

Staff initials


Date

Time given

Dose given

Name of member of staff

Staff initials


Date

Time given

Dose given

Name of member of staff

Staff initials



