Individual Healthcare Plan

CLEAR RECENT PHOTO OF CHILDS FACE, IDEALLY PASSPORT STYLE OR SCHOOL PHOTO PROVIDED BY SCHOOL

CHILD'S NAME	
DATE OF BIRTH	
MEDICAL DIAGNOSIS OR CONDITION	
CHILD'S ADDRESS	
DATE	

Emergency Contacts		
Contact 1	NAME	
	RELATIONSHIP TO CHILD	
	PHONE NUMBER - DAYTIME / WORK	
	PHONE NUMBER - MOBILE	
	PHONE NUMBER – HOME / OTHER	
Contact 2	NAME	
	RELATIONSHIP TO CHILD	
	PHONE NUMBER - DAYTIME / WORK	
	PHONE NUMBER - MOBILE	
	PHONE NUMBER – HOME / OTHER	

Clinic / Hospital Contact	
NAME	
ADDRESS (HOSPITAL / CLINIC)	
PHONE NUMBER	
GP Contact	
NAME	
ADDRESS (MEDICAL PRACTICE)	
PHONE NUMBER	

Please use the space provided to give details of any medical needs your child may have, including symptoms or signs of an issue, triggers, treatments or any equipment that may be required.

PTO

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Please use the space provided to give details of any medication that is required, as well as dosage, method of administration, side effects, whether it is self-administered and when it should be taken.

Please use the space provided to describe what constitutes an emergency regarding this medical condition and the action to take if it occurs.

Minor reaction	
Briefly describe:	
GIVE	
DOSE	
If asthmatic	
GIVE	
DOSE	
Major reaction	
Briefly describe:	
CALL 999 stating	
GIVE	
If asthmatic	
GIVE	
DOSE	
If further deterioration or no improvement after 5 – 10 minutes	
GIVE	
DOSE	

Plan developed by	
Medical professional	
PRINT NAME	
GP / HOSPITAL	
SIGNATURE	
DATE	
with parents, carers or guardians	
PRINT NAME	
SIGNATURE	
DATE	