KITE RIDGE SCHOOL
CHANGING MINDS

Student Photo

Individual Health Care Plan

Students Details

Student's Name	
Date of Birth	
Address	
Home telephone number	

Family Contact Information

Next of Kin Name	
Relationship to the student	
1st Contact number	
2nd Contact number	
Additional Emergency Contact Name	
Relationship to the student	
1st Contact number	
2nd Contact number	

Professionals Details

GP – Name and surgery	
GP – telephone number	
CAMHS (if applicable) Name of Professional involved.	
Hospital Specialist – Paediatrician, Any consultants? Name of Professional and department	
Social Worker - Name and telephone number	

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Medical Diagnosis

Please list each diagnosis below Eg – Autism, ADHD, Fragile X Syndrome	Any medication needed to support this medical diagnosis. Please list below

Medical Conditions

Medical conditions such as; *Epilepsy, Asthma, Period Pains, Anaphylaxis* Please list each condition below.	Any medication to support his condition. Please list below, medication name, amount and frequency.

Allergies

Any known Allergies? *Allergic reactions to medication, Food allergies, Hay fever* Please list individually below	Any specific treatment for the allergy. Please list below the treatment and medication if needed.

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Medical History

Any Medical History school need to be aware of *Previous Operations, hospital admissions, any previous medical consultations, broken bones.* **Please list individually below.**	**Any specific treatment for this medical treatment.** **Please list below the treatment below.** **Also the date/year of treatment**

Regular medications

Please list any regular medications the student is prescribed.

Name of medication	**Dose**	**Method of Administration** Orally, nasally	**What times are the medications administered**	**Any known side effects**	**Administered by** * self administered * Parent/carers

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school's policy.

It is my responsibility to ensure that School is informed should anything change.

Additional Forms must be completed before medications can be administered at school.

Signed by: ………………………………………………………………………………….

Name of Parent: …………………………………………………………………………….

Date: ……………………………………………………………………………………………..

Checked by

Learning Mentor:

Print Name ………………………………Signed ……………………………………….

Date: ……………………………………………………………………………………………..

Head teacher:

Print Name………………………………….Signed……………………………….

Date……………………………………………………………………………………….

Review Date – July 2019 unless any medical need change.

Arrangements for school visits/trips etc

Risk assessments are completed by school which include checking Health care plans and Epilepsy Health care plan. Parental responsibility to send in medication if needed.

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

Named First Aiders and those trained in administration of Medications. Two members of staff to administer any medications.

Plans developed with

School and Parent/Guardians

Staff training needed/undertaken – who, what, when

Staff trained in specific conditions and records are kept at school.