



Central Street Infant School

Form A

PHOTO

Health Care Plan

Name of child	
Class	
Date of birth	
Address of child	
Medical diagnosis or condition	
Date Completed	
Attendance at Meeting	
Review Date	

Family Contact Information

Name		
Relationship		
Phone Number	work	
	home	
	mobile	

Name		
Relationship		
Phone Number	work	
	home	
	mobile	

Clinic/Hospital Contact

Name	
Phone Number	

GP

Name	
Phone Number	

Describe medical needs and give details of child's symptoms

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Daily care requirements (including any side effects of medication)

(Timing of medication, Staff providing care, any impact on learning/behaviour)

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

Follow up care

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

This Health Care Plan can be shared with emergency care settings.

Form copied to:

Signatures:

Parent:	Parent:
Named Person – School:	Named Person – School:
School Nurse:	

I consent that I am happy that the above information be passed onto emergency care staff in the event of an emergency during school hours or during after school activities.

Parent/Guardian Signature.....

Date.....

Name of Parent/Guardian
(printed).....