

 **Children’s Individual Health Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| Date completed: |  | Review date: |  |

**Child’s details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name: |  | Date of birth: |  |
| Address: |  |
|  |  |
| Allergies: |  |
| Medical condition/diagnosis |  |
| Medical needs and symptoms: |  |
| Daily care requirements: |  |
| Medication details (inc. expiry date/disposal) |  |
| Storage of medication: |  |
| Procedure for administering medication: |  |
| Names of staff trained to carry out health plan procedures and administer medication: |
| N/A |
| Other information: |  |
|  |  |
| Date risk assessment completed: |  |
| Risk assessment details: |  |
|  |
| Describe what constitutes an emergency for the child, which procedures will be taken if this occurs and the names and staff responsible for an emergency with the child.  |
|  |

**Child’s main carer(s)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Name:
 |  |  |  Relationship  |  |
| Contact number(s): |  |  |
| 1. Name:
 |  |  |  Relationship: |  |
| Contact number(s): |  |  |

**Practitioner’s details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Contact number: |  |
| Address: |  |
|  |  |

**Clinic of Hospital details (if app):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Contact number: |  |
| Address: |  |
|  |  |

**Declaration**

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of parent |  | Date: |  |
| Signature: |  |
| Name of key person |  | Date: |  |
| Signature: |  |
| Name of manager: | Denise Danaher | Date: |  |
| Signature: |  |
| Date: |  |

For children requiring life saving or invasive medication and/or care, for example, rectal diazepam, adrenaline injectors, Epi Pens, Ana pens, Jext Pens, maintaining breathing apparatus, changing colostomy or feeding tubes, you must receive approval from the child’s GP/consultant, as follows:

I have read the information in this Individual Health Plan and have found it to be accurate.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of GP/consultant: | N/A | Date: |  |
| Signature: |  |

**To be reviewed at least every six months, or as and when needed.**

**Intolerance and Allergen Risk Assessment**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name  | Date | AllergenSubstance, materialOr animal | Who is at riskVisitors, those most vulnerable | Nature of reactionAnaphylactic shockRash, skin reddening,Swelling or breathingproblems | Control measureLimiting exposure to allergen | ReviewInform, Plan, Record and review |
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