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Individual Health Care Plan

Welcome to St. Johns. Thank you for advising us that your child has a medical condition or allergy. Please complete this form so we can best support your child.

Section 1: About You and Your Child

Your Name : _____

Child's Name: _____

Year Group:
☐ Reception ☐ Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐ Year 5 ☐ Year 6

Class Name: _____

How long has your child attended our school?
☐ New Starter ☐ Less than 1 year ☐ 1–2 years ☐ 3+ years

Medical Information and Support Needs

1. Medical Condition(s):

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2. Triggers, Symptoms, and Warning Signs:

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3. Treatment Plan (including medication, dosage, frequency, and method of administration) if applicable:

Name of medicine	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine
Special Instructions				
Allergies				
Other prescribed medicines				

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NOTE: Where possible the need for medicines to be administered at school should be avoided. Parents are therefore requested to try to arrange the timing of doses accordingly.

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4. Are there any side effects or storage instructions for the medication?
   ☐ Yes ☐ No
   If yes, please specify:

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5. Can your child self-manage their medication?
   ☐ Yes ☐ No ☐ With supervision
   Please explain:

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6. Written permission for medicine administration
   Do you give permission for:
   ☐ School staff to administer medicine
   ☐ Your child to self-administer medicine
   ☐ Neither
   Signed permission from:
   Parent/Carer name and signature: _____ Date: _____
   Headteacher (or delegate) signature: _____ Date: _____

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7. Other needs or adjustments (tick all that apply):
   ☐ Assistance with medication
   ☐ Access to food/drink for medical reasons
   ☐ Equipment or facilities (please specify): _____
   ☐ Environmental needs (e.g. temperature, allergens): _____

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8. Emergency Contacts
   Emergency contact 1 (Name/Number): _____
   Emergency contact 2 (Name/Number): _____
   Doctor's name and surgery contact: _____

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PLEASE ENSURE THAT EVIDENCE OF ANY MEDICAL CONDITION, ALLERGY OR INTOLERANCE IS SUPPORTED BY MEDIAL EVIDENCE AND/OR A LETTER FROM YOUR GP – THIS IS A NON-NEGOTIABLE REQUIREMENT

For Office Use Only

1. Level of support required, including during emergencies:

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2. Who will provide this support (name of staff member, if known):

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3. Training required for staff?
   ☐ Yes ☐ No ☐ Not sure

4. Cover arrangements when support staff member is unavailable:

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5. Who needs to be informed of the condition and support required?
   ☐ Teachers ☐ TAs ☐ Midday supervisors ☐ Chartwells ☐ MLH ☐ SENCO
   ☐ Other (Please list): _____

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6. Additional procedures needed for school trips or activities:

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7. If there are confidentiality concerns, who should be entrusted with this information?
   Name of staff member: _____
