Keswick School

Individual Health Care Plan (IHCP)

1. Student Information:

Name: _____ Date of birth: _____

Address: _____

2. Contact Information

Contact 1 – Name: _____ Relationship to child: _____

Mobile number: _____ Home/work number: _____

Contact 2 – Name: _____ Relationship to child: _____

Mobile number: _____ Home/work number: _____

GP Surgery: _____ Phone: _____

Specialist Contact: _____ Phone: _____

3. Medical Condition Information

Medical diagnosis or condition: _____

Describe medical needs and give details of child's symptoms, triggers, signs etc:

Daily care requirements:

Describe what constitutes an emergency, including emergency medication and the action to take if this occurs:

Name of medication(s), dose(s), method of administration, when to be taken, side effects:

Can the student self-administer the medication themselves: Yes / No

Specialist arrangements for trips and off-site visits:

4. Parental and Student Agreement:

I agree that medical information contained in this plan can be shared with individuals involved with my/my child's care (this includes emergency services). I understand that I must notify the school of any changes in writing

Student signature: _____ Date: _____

Parent signature: _____ Date: _____

Print name: _____

I consent to emergency medication being administered to my child by a member of staff in an emergency:

Parent signature: _____ Date: _____

Print name: _____

Staff signature: _____ Date: _____

FOR SCHOOL USE Date completed: Review Date: