

# FORM 1: HEALTH CARE PLAN FOR A CHILD OR YOUNG PERSON WITH MEDICAL NEEDS

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of child or young person:** | | **DOB:** | | | | **School:** | | | | **Class:** |
| **Medical condition:** | | | | | | | | | | |
| **CONTACT INFORMATION** | | | | | | | | | | |
| **Family contact 1** | **Name:** | | | | **Address:** | | | | | |
| **Phone number (Home):** | | | | **Phone number (Work):** | | | | | |
| **Relationship to child or young person:** | | | |  | | | | | |
| **Family contact 2** | **Name:** | | | | **Address:** | | | | | |
| **Phone Number (Home):** | | | | **Phone Number (Work):** | | | | | |
| **Relationship to child or young person:** | | | |  | | | | | |
| **GP, specialist**  **or**  **hospital clinic** | **Name:** | | | | **Phone Number:** | | | | | |
| **Name:** | | | | **Phone Number:** | | | | | |
| **PLAN PREPARATION AND DISTRIBUTION** | | | | | | | | | | |
| **Prepared by** | **Name:** | | | | **Designation:** | | | | **Date:** | |
| **Distributed to** | **Parent/carer:** | | **GP:** | | | | **Clinic:** | **Other:** | | |
| **Describe the child or young person's medical condition and details of its impact on child or young person in school:** | | | | | | | | | | |
| **Medication:** | | | | **Details of dose:** | | | | | | |
| **Method and time of administration:** | | | | | | | | | | |
| **Daily care requirements (e.g. before sport; dietary; therapy; nursing needs):** | | | | | | | | | | |
| **Action to be taken in an emergency:** | | | | | | | | | | |

|  |
| --- |
| **Follow up care:** |
| **Members of staff trained to administer medication for this child or young person:**  ***(Please state if different for off-site activities/school trips)*** |

**Briefing of staff by health practitioner**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of staff member:** | | | | |
| **Type of training received:** | | | | |
| **Date training was completed:** | | | | |
| **Training provided by:** | | | | |
| I confirm that has received the training detailed above and is competent to:  (i) administer the medication prescribed  (ii) carry out the procedure described above  *(delete as appropriate)* | | | | |
| **Trainer's signature:** | | | **Date:** | |
| I confirm that I have received training detailed above. | | | | |
| **Trainee's signature:** | | | **Date:** | |
| Suggested date for refresher training: |  | Suggested date for refresher training: | |  |
| Suggested date for refresher training: |  | Suggested date for refresher training: | |  |
| Suggested date for refresher training: |  | Suggested date for refresher training: | |  |
| Suggested date for refresher training: |  | Suggested date for refresher training: | |  |
| **HOW WE USE YOUR PERSONAL INFORMATION**  The information provided by you will be used by Perth & Kinross Council to ensure that your child, or the child for whom you have parental responsibility, receives the correct medication and that they receive appropriate medical treatment when required. This information may also be shared with NHS staff if necessary. It will also be shared if we are required to do so by law.  For further information, please look at our website [*www.pkc.gov.uk/dataprotection*](http://www.pkc.gov.uk/dataprotection)*; email* [*dataprotection@pkc.gov.uk*](mailto:dataprotection@pkc.gov.uk) or phone 01738 477933. | | | | |

# 