# coldfall badge (colour)Child healthcare plan

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| Name of school/setting |  |
| Child’s name |  |
| Group/class/form |  |
| Date of birth |  |  |  |  |
| Child’s address |  |
| Medical diagnosis or condition |  |
| Date |  |  |  |  |
| Review date |  |  |  |  |
| **Family Contact Information** |  |
| Name |  |
| Relationship to child |  |
| Phone no. (work) |  |
| (home) |  |
| (mobile) |  |
| Name |  |
| Relationship to child |  |
| Phone no. (work) |  |
| (home) |  |
| (mobile) |  |
| **Clinic/Hospital Contact** |  |
| Name |  |
| Phone no. |  |
| **G.P.** |  |
| Name |  |
| Phone no. |  |

(PTO)

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| Who is responsible for providing support in school |  |

Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

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Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

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Daily care requirements

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Specific support for the pupil’s educational, social and emotional needs

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Arrangements for school visits/trips etc

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Other information

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

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

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Parental agreement to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) Date