



## HEALTH CARE PLAN FOR A PUPIL WITH MEDICAL NEEDS

CHILD'S NAME:

DATE:

DATE OF BIRTH:

PHOTO OF CHILD

MEDICAL CONDITION:

CLASS:

CONTACT INFORMATION:

FAMILY CONTACT 1

FAMILY CONTACT 2

NAME:

NAME:

PHONE NO. (Work)  
(Home)

PHONE NO. (Work)  
(Home)

RELATIONSHIP:

RELATIONSHIP:

G.P.

NAME:

PHONE NO.

DESCRIBE CONDITION AND GIVE DETAILS OF  
PUPIL'S INDIVIDUAL SYMPTOMS.

DESCRIBE WHAT CONSTITUTES AN EMERGENCY FOR THE PUPIL, AND THE ACTION TO BE TAKEN IF THIS OCCURS

DAILY CARE REQUIREMENTS (E.G. before sport/at lunchtime.

INHALER/MEDICATION PROVIDED TO SCHOOL

YES/NO

PLEASE GIVE DETAILS OF MEDICATION PROVIDED.