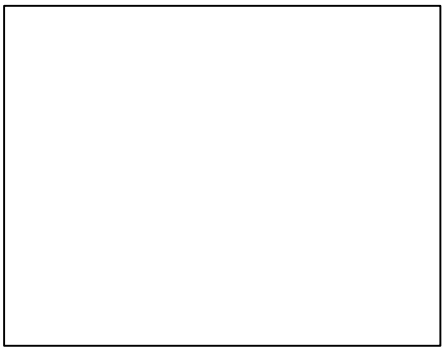
Individual health care plan **CONFIDENTIAL**

Child's name: Date: 	Date of birth: Gender:	Home Address:
Sessions child attends-please tick		
After School club		
Monday		☐
Tuesday		☐
Wednesday		☐
Thursday		☐
Friday		☐

This is my condition/medical diagnosis:	These are my symptoms:	
This is how I need you to help me every day:	In an emergency this is what might happen:	
If this happens I need you to:	If you need to phone the ambulance say:	
Afterwards I need you to:	Please phone on:	
	Please phone on:	
	Please also phone on:	
My doctor is:	My hospital contact is:	
The medication I need is:	I have completed a medication consent form	Please tick ☐
This plan will be updated on:	My parent's signature:	
	Date:	

As this child's parents I understand that it is my responsibility to update the setting if any of this information needs to be changed.

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