Individual Healthcare Plan (IHP)

**Childs Information;**

|  |  |
| --- | --- |
| **Name** |  |
| **Class** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Medical Need or Condition Diagnosis** |  |
| **Date of IHP** |  |
| **Review Date** |  |

**Parents/Carers Information;**

|  |  |  |
| --- | --- | --- |
| **Name** | **Designation** | **Contact Numbers** |
|  |  |  |
|  |  |  |
|  |  |  |

**Medical Professionals Contact Information;**

|  |  |  |
| --- | --- | --- |
| **Name** | **Designation & Hospital/Clinic** | **Contact number / email** |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Describe medical needs and give details of child’s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.** |
| **Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision.** |

|  |
| --- |
| **Daily Care Requirements** |

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| **Specific Support for SEMH** |

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| --- |
| **Arrangements for Trips** |

|  |
| --- |
| **Any other Information or Reasonable Adjustments required** |

**Emergency Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **What happens** | **Actions needed** | **By whom** | **Responsibility** |
|  |  |  |  |
|  |  |  |  |

**Actions**

|  |  |  |  |
| --- | --- | --- | --- |
| **Action** | **Training Need** | **Who** | **By When** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Signed (parent/Carer)**…..............................................................................................................

**Signed (school)**…........................................................................................................................

**Date** ……………………………………………………………………………………………………………………………………..

*To be shared with:*