Health Care Plan for a pupil with medical needs

Name of pupil:

D.O.B:

Condition:

Class:

Child's Address:

Date form Completed:

PHOTO

FAMLY CONTACT INFORMATION

Mother :

Father :

Emergency contact in absence of parents :

HEALTH PROFESSIONALS INVOLVED IN [YOUR CHILD'S] CARE

Lead Clinician :

Local Hospital No :

GP :

Medical needs and details of any symptoms plus medication:

Daily requirements:

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SPECIAL NEEDS REQUIREMENT [where applicable] :

SPORT/PHYSICAL ACTIVITIES

Emergency situations: