HEALTH CARE PLAN FOR CHILDREN WITH MEDICAL NEEDS

Name:		
Date of Birth:		
Medical diagnosis or condition		
Date to be reviewed		

FAMILY CONTACT INFORMATION			
Contact 1		**Contact 2**	
Name:		Name:	
Daytime Phone:		Daytime Phone:	
Home Phone:		Home Phone:	
Mobile Phone:		Mobile Phone:	
Email address:		Email Address:	
Relationship:		Relationship:	
Clinic/Hospital contact:		**GP:**	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	

Describe medical needs/condition and give details of child's individual symptoms:

Describe daily care requirements (e.g. before / at lunchtime. As and when required)	
Dosage to been given.	
Describe what constitutes an emergency for the child and the action to take if this occurs:	
Follow up care:	
Any other information?	
I give my permission for Pre-School staff to administer the above medication as instructed. **Signed…… Print name……..** **Date……**	
Staff member who actioned this plan. **Signed…… Print name……** **Date……**	