

ENFIELD EDUCATION AUTHORITY

HEALTH CARE PLAN FOR A PUPIL WITH MEDICAL NEEDS

SCHOOL :

PUPIL DETAILS:

Name	PHOTO
Date of Birth	
Medical Condition	
Class/Year Group	
Date	Review Date

To be reviewed at least annually

CONTACT INFORMATION

Family Contact 1	Family Contact 2
Name	Name
Phone number Work Home Mobile	Phone number Work Home Mobile
Relationship	Relationship
Clinic/Hospital Contact	G.P.
Name	Address
Phone No.	Phone No.

Describe condition and give details of pupil's individual symptoms

Daily care requirements (e.g before sport/at lunchtime)

Describe what constitutes an emergency for the pupil, and the action to take if this occurs:

Follow up care:

Who is responsible in an emergency (state if different for off site activitie

Form copied to:

Signature of parent/carer

Name of parent/carer: (please print)

.....

Signature of parent/carer:

.....

Date:

Dear Parent/Carer of,

Please find enclosed the Care Plan for your son/daughter

If you agree with the Care Plan can you please sign the Parent/Carer Signature page and return to school or alternatively if you would like something changed or added to the Care Plan can you please put this in writing. We will then alter the Care Plan and send you a new copy to sign.

Yours sincerely,

Annwara Chowdhury

Welfare Officer