Health Care Plan for:

DOB

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Health Care Plan - Managing Medicines Name of school Child's name Form class Date of birth Child's address Medical diagnosis or condition Family information/emergency contact 1. Parent/carer Phone no. (home) (work) (mobile) 2. Emergency contact (name) Phone no. (home) (work) (mobile) **Health contact** Name Phone no G.P. Name Phone no

Outline med	ical needs and give details	of child's symptoms	5	
		<u> </u>		
List any regu	lar medication taken by the	e child		
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Daily manag lunchtime	ement of medication (inc	luding emergency	care) e.g. befor	re sport/at
Form copied	to:			