STOCKPORT
METROPOLITAN BOROUGH COUNCIL

Stockport NHS
NHS Foundation Trust

Form 1 - Individual Health Plan

For pupils with complex health needs at school

Medical Condition_____

Date form completed:		
Date for review:		
Reviewed by	**Date** *(dd/mm/yyyy)*	**Changes to Individual Health Plan**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
Copies held by:		

1. Pupil's Information		
Name of School:		
Name of Pupil:		
Class / Form		
Date of Birth:	Male ☐ Female ☐	
2. Contact Information		
Pupil's Address	Postcode:	
Family Contact Information		
a.	Name:	
	Phone (Day):	
	Phone (Evening):	
	Mobile:	
	Relationship with Child:	
b.	Name:	

	Phone (Day):	
	Phone (Evening):	
	Mobile:	
	Relationship with Child:	

GP	
Name:	
Phone:	
Specialist Contact	
Name:	
Phone:	

Medical Condition Information	
3. Details of Pupil's Medical Conditions	
Signs and symptoms of this pupil's condition:	
Triggers or things that make this pupil's condition/s worse:	
4. Routine Healthcare Requirements ***(For example, dietary, therapy, nursing needs or before physical activity)***	
During school hours:	
Outside school hours:	
5. What to do in an Emergency	
Signs & Symptoms	
In an emergency, do the following:	
6. Emergency Medication ***(Please complete even if it is the same as regular medication)***	
Name / Type of medication	

(as described on the container):	
How the medication is taken and the amount:	
Are there any signs when medication should not be given?	
Are there any side effects that the school needs to know about?	
Can the pupil administer the medication themselves? *(please tick box)*	☐ Yes ☐ No ☐ Yes, with supervision by: Staff members name:
Is there any other follow-up care necessary?	
Who should be notified? *(please tick box)*	☐ Parents ☐ Carers ☐ Specialist ☐ GP
7. Regular Medication taken during School Hours	
Name/type of medication (As described on the container):	
Dose and method of administration (The amount taken and how the medication is taken, e.g. tablets, inhaler, injection)	
When it is taken (Time of day)?	
Are there any side effects that could affect this pupil at school?	
Are there are any contraindications (Signs when this medication should not be given)?	
Self-administration: can the pupil administer the medication themselves?	*(Tick as appropriate)* ☐ Yes ☐ No ☐ Yes, with supervision by: Staff member's name:
Medication expiry date:	
8. Regular Medication taken outside of School Hours ***(For background information and to inform planning for residential trips)***	

Name/type of medication (as described on the container):	
Are there any side effects that the school needs to know about that could affect school activities?	
9. Members of Staff Trained to Administer Medications for this Pupil	
Regular medication:	
Emergency medication:	
10. Any Other Information Relating to the Pupil's Healthcare in School?	

Parental and Pupil Agreement	
I agree that the medical information contained in this plan may be shared with individuals involved with my/my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing.	
Signed (Pupil)	
Print Name:	
Date:	
Signed (Parent) *(If pupil is below the age of 16)*	
Print Name:	
Date:	

Healthcare Professional Agreement	
I agree that the information is accurate and up to date.	
Signed:	
Print Name:	
Job Title:	
Date:	

Permission for Emergency Medication
☐ I agree that I/my child can be administered my/their medication by a member of staff in an emergency