# Complex health care plan

|  |  |
| --- | --- |
| Name of setting |  |
| Child’s full name |  |
| Date of birth |  |
| Child’s full address |  |
| Medical diagnosis or condition: |  |

**Child’s family contacts**

|  |  |  |  |
| --- | --- | --- | --- |
| 1st parent / guardian’s name |  | Contact phone number |  |
| 2nd parent / guardian’s name: |  | Contact phone number |  |
| Family / friend emergency contact name |  | Contact phone number |  |

**Child's health professional contacts**

|  |  |  |  |
| --- | --- | --- | --- |
| Consultant’s name |  | Contact phone number |  |
| G. P’s name |  | Contact phone number |  |
| 1st therapist’s name |  | Contact phone number |  |
| 2nd therapist’s name |  | Contact phone number |  |
| Social worker’s name |  | Contact phone number |  |
| Other  name |  | Contact phone number |  |

**Child's daily requirements**

|  |  |
| --- | --- |
| Describe the child's medical needs: |  |
| Daily equipment needs: |  |
| Daily continence needs: |  |
| Daily medication needs: |  |
| Known allergies: |  |

**Child's emergency medication and care**

|  |  |
| --- | --- |
| What constitutes an emergency for the child |  |
| Signs the child will display to indicate an emergency: |  |
| Symptoms the child will display to indicate an emergency: |  |
| General action to take if emergency occurs:  i.e. name of person responsible in emergency, duty to carry out |  |
| Additional action to take if emergency occurs:  i.e. name of medication, dosage, time of administration |  |
| Follow up care required for the child: |  |

**Child's other specific requirements**

|  |  |
| --- | --- |
| Training required of staff for care of child: |  |
| Expertise required of staff for care of child: |  |
| Name of person compiling health care plan: |  |
| Date of completion: |  |

## Parent/ Guardian’s consent and signature

* I, the child's parent/guardian, consent to the above instructions and procedure being carried out in the setting for my child.
* I consent to the information in this health care plan being shared with others.
* I agree the health care plan reflects my child's current health care needs.
* I agree to notify the setting SENCO immediately if my child's needs alter or change so they health care plan may be updated and reviewed sooner than 6 months.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1st parent / guardian’s name |  | 1st parent / guardian’s signature |  | Date of signature |  |
| 2nd parent / guardian’s name |  | 2nd parent / guardian’s signature |  | Date of signature |  |

## Health care professional’s agreement and signature

* I agree this health care plan reflects the child's current health needs.
* I agree this health care plan is correct and should be used as a direct instruction and procedure for the setting staff to carry out medication and care for the child.

|  |  |  |  |
| --- | --- | --- | --- |
| Health care professional’s name |  | Health care professional’s job role |  |
| Health care professional’s signature |  | Date of health care professionals’ signature: |  |

## Settings agreement and signature

I agree to follow this health care plan in the setting to care for the child's needs and to ensure all staff in the setting use this health care plan for the child.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Setting’s representatives  name |  | Setting’s representatives  signature |  | Date of signature |  |

## Health Care Plan (HCP) to be reviewed every 6 months

If child's needs alter/change setting to be immediately notified by the child's parent/guardian and the health care plan to be immediately reviewed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of review | No Changes – HCP still current? Y / N | Changes to be made – HCP to be deleted? Y / N | Signed by: | Date: |
| Date of review | No Changes – HCP still current? Y / N | Changes to be made – HCP to be deleted? Y / N | Signed by: | Date: |