# PERSONAL CARE PLAN

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| CHILD OR YOUNG PERSONS NAME | DoB | YEAR | SETTING/SCHOOL | COMPLETED BY | DATE OF PLAN | PLAN No. |

|  |  |
| --- | --- |
| REASONS FOR PLAN: | PROPOSED REVIEW DATE: |

**Details of assistance required:**

|  |  |  |
| --- | --- | --- |
| *What?* | *When?* | *How often?* |
| *Who?* | *Regular support* | *Name* |
|  | *Backup support* | *Names:* |

|  |
| --- |
| ***Who will liaise with parents/carers?*** |

***Facilities and equipment:***

|  |  |
| --- | --- |
| *Location of toilet?*  *Adaptations?*  *Physical assistance/manual handling?*  *Provision and storage of supplies?*  *Disposal?* |  |

***Additional considerations:***

|  |  |
| --- | --- |
| *Implications for?*  *PE, Games and Swimming*  *Extended day*  *Off site activities*  *Home/school transport* |  |

***Training requirements: (Individual staff should keep signed/dated records of any training received)***

|  |  |
| --- | --- |
| *General awareness*  *Specific individual training*  *Manual handling training*  *Risk assessment* |  |

***Procedures for monitoring arrangements:***

|  |  |
| --- | --- |
| *Record of intervention*  *Compliments/concerns*  *Review procedures and mechanism for communicating changes* |  |

***This plan has been agreed by:***

|  |  |  |  |
| --- | --- | --- | --- |
|  | NAME | SIGNATURE | DATE |
| SENCo |  |  |  |
| PARENTS/CARERS/PUPIL |  |  |  |
| IDENTIFIED SUPPORT STAFF |  |  |  |
| HEALTH CARE PROFESSIONAL |  |  |  |
| EXTERNAL AGENCIES |  |  |  |