EYFS Individual Healthcare Plan (IHP)

(Supporting children with complex health needs in EYFS)

Settings must follow:

* [**Early years foundation stage (EYFS) statutory framework 2024**](https://www.gov.uk/government/publications/early-years-foundation-stage-framework--2)
* [**Equality Act 2010**](https://www.legislation.gov.uk/ukpga/2010/15/contents)
* [**Disabled Children and the Equality Act 2010: What Early Years providers need to know and do (Council for Disabled Children, 2023)**](https://councilfordisabledchildren.org.uk/sites/default/files/uploads/attachments/Equality%20Act%20Guide%20for%20EY%20-%20FINAL.pdf)
* [**SEND code of practice 2015**](https://www.gov.uk/government/publications/send-code-of-practice-0-to-25)
* [**Children and Families Act 2014**](https://www.legislation.gov.uk/ukpga/2014/6/contents)

|  |  |
| --- | --- |
| 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**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Professional’s name | Contact phone number and/or email | Description of supporting evidence and date provided  |
| Consultant e.g. Hospital or Community |  |  |  |
| GP or GP practice |  |  |  |
| Nursing team e.g. Orchard Nurses |  |  |  |
| Therapist e.g. Physiotherapy, Occupational Therapy |  |  |  |
| Other |  |  |  |

**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: |  |
| Any other reasonable adjustments needed not covered by above: |  |
| 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 healthcare plan being shared with others.
* I agree the healthcare plan reflects my child's current healthcare needs.
* I agree to notify the setting SENCO immediately if my child's needs alter or change so the healthcare plan may be updated and reviewed sooner than 6 months.
* I agree the setting can contact the health professionals listed in this plan.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 |  |

# Settings agreement and signature

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Setting’s representativesname |  | Setting’s representativessignature |  | Date of signature |  |

# Individual Healthcare Plan (IHP) 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 healthcare plan to be immediately reviewed with any professionals involved.

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