Bizzy Bees Pre-School CIO
Memorial Hall Bedford Road
Wootton
Bedford
MK43 9JB
Tel: 01234 767785
Website: www.bizzybeespreschool.org
Email: bizzybeespre_school@btconnect.com
Charity Number: 1172751
Ofsted: EY556019

6.8 Individual health plan policy

This form must be used alongside the individual child's registration form which contains emergency parental contact and other personal details.

Date completed: _____ Review date: _____

Child's details:

Full name: _____ Date of birth: _____

Address: _____

_____

Allergies: _____

Medical condition/diagnosis _____

Medical needs and symptoms: _____

Daily care requirements: _____

Medication details (inc. expiry date/ disposal): _____

Storage of medication: _____

Procedure for administering medication: _____

Names of staff trained to carry out health plan procedures and administer medication:

_____

Other information: _____

_____

Date risk assessment completed: _____

Risk assessment details: _____

Describe what constitutes an emergency for the child, what procedures will be taken if this occurs and the names of staff responsible for an emergency situation with the child:

_____

Child's main carer(s):

1. Name: _____ Relationship to child: _____

Contact number(s): _____

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2. Name: _____ Relationship to child: _____

Contact number(s): _____

General Practitioner's details:

Name: _____ Contact number: _____

Address: _____

_____

Clinic of Hospital details (if app):

Name: _____ Contact number: _____

Address: _____

_____

Declaration

I have read the information in this health plan and have found it to be accurate. I agree for the recorded procedures to be carried out:

Name of parent: _____ Date: _____

Signature: _____

Name of key person: _____ Date: _____

Signature: _____

Name of manager: _____ Date: _____

Signature: _____

For children requiring life saving or invasive medication and/or care, for example, rectal diazepam, adrenaline injectors, Epipens, Anapens, JextPens, maintaining breathing apparatus, changing colostomy or feeding tubes, you must receive approval from the child's GP/consultant, as follows: I have read the information in this Individual Health Plan and have found it to be accurate.

Name of GP/consultant: _____ Date: _____

Signature: _____

To be reviewed at least every six months, or as and when needed. Copied to parents and child's personal file (with registration form).