

Park Farm Road Folkestone

Kent CT19 5DN

**School** - 01303 847555

*Please call the*

*Multi Agency Support Team*

*For any further information*

**Health Care Plan (HCP)**

**Pupil Name**

The purpose of this document is to gather information in regards to an individual pupils direct and indirect health care needs, to ensure that the pupil is able to access his/her education in a safe and secure environment.

**THIS DOCUMENT FORMS PART OF THE ADMISSION PROCESS FOR PUPILS.**

|  |
| --- |
| **Two week process**  |
| **Once completed the School Nurse has overall responsibility for medical issues**  |
| **Step 1** | For new admissions the whole document is sent home for parent/carers to complete. |
| **Step 2** | For pupils who have already been through the admission process and for updates and reviews the School Nurse and Admin Team will populate this document with the information on file - Parent/carers then complete any outstanding items.  |
| **Step 4** | HCP where there is deemed to be a medical need the School Nurse will take the lead.  |
| **Step 5** | Parent/Carers send back the signed hand written/partially typed HCP - **Draft Date.** |
| **Step 6** | The school add this information onto an electronic version of the HCP. |
| **Step 7** | The school send out an electronic version of the HCP plan for parent/carers to check and complete the final signature sign. |
| **Step 8** | The plan goes live. |
| Reviewed annually at EHCP and/or where required. |
| **Draft Date**  |   | **Live Date**  |  |
| *Please ensure that the Parent/Carer signs this document as a draft, enabling it to be used immediately*  |

**In the case of an emergency this document is be taken to the Hospital**

**plus all the Pupils medication and paperwork**

**Please answer all sections OR**

**PUT A LINE THROUGH THE *TITLE* OF EACH SECTION THAT IS NOT APPROPRIATE**

|  |  |  |
| --- | --- | --- |
| **Does the named pupil require an individual Risk Assessment**  | **YES** | **NO** |
| **If yes please state date completed** |  |
| **If your child does not have any medical conditions they ay not require an individual Health Care Plan** |
| My child does not require an individual Health Care Plan |
| Print Name |  |
| Sign Name |  |
| Date  |  |
| It is the responsibility of the parent guardian to inform the school of any changes |

|  |
| --- |
| **The lead people for each section - there will be overlap** |
| School Nurse | Admin |
| Parent/Carer | Class Teacher/HLTA/Key Worker |

**Contents**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **#** | **Updated by** | **Item** | **Completed** | **Page #** |
|  | **ID Colour** |  |  |  |
| **1a** |  |  | Pupil information  |  | 3 |
| **1b** |  |  | Parent/carer information  |  | 3 |
| **1c** |  |  | Emergency Contact |  | 3 |
| **2** |  |  | Brief medical history  |  | 3 |
| **2a** |  |  | Allergy information  |  | 4 |
| **2b** |  |  | Medical History |  | 4 |
| **3** |  |  | Current interventions |  | 4 |
| **3a** |  |  | Professionals information |  | 5 |
| **4** |  |  | Transport |  | 5 |
| **5** |  |  | High Risk Medical  |  | 6 |
| **6** |  |  | Enterally Fed |  | 7 |
| **7** |  |  | Food/Eating  |  | 8 |
| **8** |  |  | Mobility  |  | 9 |
| **9** |  |  | Physical Disabilities  |  | 9 |
| **10** |  |  | Medicines - PRN Process |  | 9 |
| **11** |  |  | Specialist Therapies  |  | 10 |
| **12** |  |  | Visual Impairment  |  | 11 |
| **13** |  |  | Hearing  |  | 11 |
| **14** |  |  | Tactile Sensitivity  |  | 11 |
| **15** |  |  | Emotional Well-being  |  | 11 |
| **16** |  |  | Self-harm |  | 12 |
| **17** |  |  | Transitions  |  | 12 |
| **18** |  |  | Dressing |  | 13 |
| **19** |  |  | Toilet/Hygiene |  | 13 |
| **20** |  |  | Eating Drinking checklist |  | 14 |
| **21** |  |  | Signatory and audit information  |  | 15 |

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| --- | --- | --- | --- |
|  **1** | **Pupil Information** | Admin | Parent/Carer |

|  |  |  |  |
| --- | --- | --- | --- |
| **1a** | **Pupil** | Admin | Parent/Carer |

|  |  |  |  |
| --- | --- | --- | --- |
| Pupil Name |  | DOB |  |
| NHS Number |  | Year Group  |  |
| Current Address | House Number/Name |  |
| Street/Road |  | Town |  |
| County  |  | Post Code |  |
| Home Phone # |  | Mobile # |  |
| **Who has Parental Responsibility**  |  |
| Please state contact person if Corporate Parenting? |  |
| English as an additional Language  | Yes No |
| Home language |  | Interpreter Required  | Yes No |

|  |  |  |  |
| --- | --- | --- | --- |
| **1b** | **Parent/Carer Information** | Admin | Parent/Carer |

|  |
| --- |
| **Permanent Parent/Carer information** |
| **1** | Full Name |  | Relationship  |  |
| Mobile # |  | E-mail Address |  |
| **2** | Full Name |  | Relationship  |  |
| Mobile # |  | E-mail Address |  |
| Address - *only complete if different from above* |
| Current Address | House Number/Name |  |
| Street/Road |  | Town |  |
| County  |  | Post Code |  |
| Home Phone # |  | Mobile # |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **1c** | **Emergency Contact Information**  | Admin | Parent/Carer |

|  |
| --- |
| Who else can we contact in a health emergency?  |
| **1** | Full Name |  | Relationship  |  |
| Mobile # |  | E-mail Address |  |
| **2** | Full Name |  | Relationship  |  |
| Mobile # |  | E-mail Address |  |

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| --- | --- | --- |
| **2** | **Please provide a brief medical history?** | Parent/Carer |
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| **2a** | **Allergies** | Admin | Parent/Carer |

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| --- |
| **Please list any known allergies and any processes** |
| **Allergic to** | **What should be done** |
|  |  |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **2b** | Medical History Continued | Admin | Parent/Carer |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | √ |  | Year/s |
|  |  |  |  |
| Whooping Cough |  |  |  |
| Measles  |  |  |  |
| Scarlet Fever  |  |  |  |
| Mumps |  |  |  |
| Chicken Pox |  |  |  |
| German  |  |  |  |
| Poliomyelitis  |  |  |  |
| Diphtheria |  |  |  |
| Serious Accidents  |  |  |  |
| Ear Trouble |  |  |  |
| Other Illness |  |  |  |
| Other Illness |  |  |  |

Please give the year of your child’s most recent vaccination or immunisation against

|  |  |  |  |
| --- | --- | --- | --- |
| Name | √ |  | Year/s |
|  |  |  |  |
| Tuberculosis |  |  |  |
| Diphtheria  |  |  |  |
| Whooping Cough |  |  |  |
| Tetanus  |  |  |  |
| MMR |  |  |  |
| Meningitis C |  |  |  |
| Other/ |  |  |  |
| Other/ |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **3** | **Current interventions** | Admin | Parent/Carer |

Please complete for additional information from Specialist Therapists

|  |  |  |  |
| --- | --- | --- | --- |
| Name | **√** | Tick if there is a written report | Where found |
|  |  |  |  |
| Speech and Language (feeding) |  |  |  |
| Speech and language (communication ) |  |  |  |
| Occupational Therapy |  |  |  |
| GP |  |  |  |
| Psychologist/Mental Health  |  |  |  |
| Physiotherapy  |  |  |  |
| Other  |  |  |  |
| **3a** | **Professional/s Information** | Admin | Parent/Carer |

Please provide us with information on any Health Professionals who are now or have been actively involved over the last two years, e.g. Speech and Language, Occupational Therapist, Psychologist, Interpreter?

*Where possible please attach any reports to this document*

*they form a complete overview of the pupils Health Care Needs*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1** | Full Name |  | Department  |  |
| Job Title |  | Involved Since |  |
| Phone # |  | E-mail Address |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | Full Name |  | Department  |  |
| Job Title |  | Involved Since |  |
| Phone # |  | E-mail Address |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **3** | Full Name |  | Department  |  |
| Job Title |  | Involved Since |  |
| Phone # |  | E-mail Address |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **4** | Full Name |  | Department  |  |
| Job Title |  | Involved Since |  |
| Phone # |  | E-mail Address |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **5** | Full Name |  | Department  |  |
| Job Title |  | Involved Since |  |
| Phone # |  | E-mail Address |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **6** | Full Name |  | Department  |  |
| Job Title |  | Involved Since |  |
| Phone # |  | E-mail Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **4** | **Transport** | Admin | Parent/Carer |

How does your child travel to school?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Public Bus |  | School Bus |  | Taxi |  | Parent/Carer |  | Other (pls state) |  |

Please complete information in regards to transport.

|  |  |
| --- | --- |
| Company Name |  |
| Contact Person |  |
| Contact # |  |
| Is the transport  | **AM** | Yes No | **PM** | Yes No |
| Does your child require an escort? | Yes No |
| Does your child require a harness? | Yes No |
| Does your child require a booster? | Yes No |

|  |  |  |  |
| --- | --- | --- | --- |
| **5** | **High Risk Medical** | School Nurse | Parent/Carer |

Medication form will also need to be completed/additional forms can be added

|  |  |
| --- | --- |
| Key Staff member for Audit  | School Nurse  |

|  |  |
| --- | --- |
| **Name the medication if linked to this form** |  |

*Main medical professionals for hospital information - (additional information on pupils red files)*

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Involvement**  |
|  |  |  |
|  |  |  |
|  |  |  |

***Emergency Action Plan - please describe in DETAIL what you need to do***

|  |
| --- |
| What makes the emergency? |
|  |
|  |

|  |  |
| --- | --- |
| # | **Describe in very clear small steps what needs to be done** |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |
| **5** |  |
| **6** |  |
| **7** |  |
| **8** |  |
| **9** |  |
| **10** |  |
| **11** |  |
| **12** |  |
| **13** |  |
| **14** |  |
| **15** |  |
| ***Who needs to be contacted and in what order***  |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |
| **5** |  |

|  |
| --- |
| ***Who are the key people responsible in an emergency (school)*** |
| **1** |  |
| **2** |  |

|  |
| --- |
| ***Any further information***  |
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|  |
| **6** | Enterally Fed | School Nurse | Parent/Carer |

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| --- | --- | --- |
| **Item** | **Information**  | **Exception** |
| Time frame for CP |  |  |
| Device type |  |  |
| Feeding regime |  |  |
| Flushing |  |  |
| Size of syringe for giving feeds |  |  |
| Type of syringe |  |  |
| Use of syringe |  |  |
| Cleaning/Storage |  |  |
| Water |  | water does not have to be sterile if gastrostomy or nasogastric tubeaa  |
| Changing tubes |  |  |
| Position of device |  |  |
| Care of device/Pupil |  |
| **This judgement is made in consultation with the family and GP** |

|  |  |  |  |
| --- | --- | --- | --- |
| **7** | **Food/eating** | School Nurse | Parent/Carer |

|  |  |  |
| --- | --- | --- |
| **Item** | **Information**  | **√** |
| Level of Supervision  | Requires constant supervision – **High Risk of Choking**  |  |
| **High Risk Medical must be completed** |
| Require close supervision – e.g. in a small group |  |
| Requires some assistance – verbal reminder  |  |
| Independent  |  |
| Time required to eat meal | Less than 15 minutes – NHS standard time |  |
| More than 15 minutes |  |
| State usual amount of time  |  |  |
| Type of Support(please explain)  | Additional Hygiene safety measures |  |  |
| Positioning for comfort and safety  |  |  |
| Facilitation – Jaw support  |  |  |
| Stimulation – facial tapping  |  |  |
| other |  |  |
| Equipment | Clothes protector  |  | Modified cup/plate |  |
| Modified utensils |  | Mirror |  |
| Positioning equipment – cushion/chair  |  |
| Other |  |  |
| Environmental | Calm consistent approach |  | Minimal distractions |  |
| Positive reinforcement |  | Other |  |
| Social settings |  |  |
| After eating support | Need to remain seated  |  |
| Need to check mouth is free of food |  |
| Requires teeth brushing  |  |
| Other |  |  |
| Communication (explain support) | Verbal  |  | Visual |  |
| Gestural |  | Other |  |
| Food consistency  | No restriction |  |
| Modified - Explain  |  |  |
| Food Portions  | No restriction on amount at any one time |  |
| Modified - Explain  |  |  |
| Drink consistency  | No restriction  |  |
| Modified - Explain  | *Information sought from SALT* |  |
|  |
|  |
|  |
| Drink Portions  | No restriction on amount at any one time  |  |
| Modified - Explain  |  |  |
| Specific Strategies  | Eats with a spoon |  |
| Eats with fingers |  |
| Uses cutlery  |  |
| Other |  |  |
| Preferences | Favourite Foods |  |  |  |
|  |  |  |  |
| Disliked Foods |  |  |  |
|  |  |  |  |
| Do they require regular snacks  | **Yes No** |
|  |  |  |  |
| Allergies linked to foods (as Above) |  |  |  |
| **8** | **Mobility** | School Nurse | Parent/Carer |

|  |  |  |
| --- | --- | --- |
| **Environment** | **Answer Yes/No** | **What are the main issues** |
| In the class |  |  |
| Other school rooms |  |  |
| School grounds |  |  |
| Transport |  |  |
| Public places |  |  |
| Community general |  |  |
| Stairs |  |  |
| Slopes/Hills |  |  |
| Escalators  |  |  |
| Lifts  |  |  |
| Other  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **9** | **Physical Disabilities** | School Nurse | Parent/Carer |

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| --- | --- |
| **List below areas affected**(e.g. Hands) | **How does this impact on their General Health and Learning?**  |
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| --- | --- | --- | --- |
| **10** | Medicines - PRN Process | School Nurse | Parent/Carer |

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| --- | --- | --- |
| Is your child currently on medication | Yes No | Please give medication information and complete medication form for medicines to be taken while in school |

|  |  |  |
| --- | --- | --- |
| Name of Medication  | Why Given | When to be administered  |
|  |  |  |
|  |  |  |
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| **Federation Process for PRN Medication (over the counter medications)** |
| *For staff to be able to administer medication on a ‘When Required’ basis* *the following actions need to be followed* by the *parent/carer* |
| **Written information on;** |
| **1** | What is the medication for? |
| **2** | What is the dose? |
| **3** | When was it last given? |
| **4** | When is it next to be given? |
| **5** | The information MUST be signed  |
| PRN (when required medication) can only be administered for a maximum of 48 hours, unless authorised by Medical Specialist  |
| **11** | Specialist Therapies - standing frames/slings etc. | School Nurse | Parent/Carer |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1** | Item name and ID |  | Date Supplied  |  |
| Last Serviced |  | Next Service  |  |
| Contact  |  | Name |  | Number  |  |
| What/How is it used |  |
| Additional Information |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | Item name and ID |  | Date Supplied  |  |
| Last Serviced |  | Next Service  |  |
| Contact  |  | Name |  | Number  |  |
| What/How is it used |  |
| Additional Information |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **3** | Item name and ID |  | Date Supplied  |  |
| Last Serviced |  | Next Service  |  |
| Contact  |  | Name |  | Number  |  |
| What/How is it used |  |
| Additional Information |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **4** | Item name and ID |  | Date Supplied  |  |
| Last Serviced |  | Next Service  |  |
| Contact  |  | Name |  | Number  |  |
| What/How is it used |  |
| Additional Information |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **5** | Item name and ID |  | Date Supplied  |  |
| Last Serviced |  | Next Service  |  |
| Contact  |  | Name |  | Number  |  |
| What/How is it used |  |
| Additional Information |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **6** | Item name and ID |  | Date Supplied  |  |
| Last Serviced |  | Next Service  |  |
| Contact  |  | Name |  | Number  |  |
| What/How is it used |  |
| Additional Information |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **12** | **Visual Impairment** | School Nurse | Parent/Carer |

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| --- | --- |
| **What type of visual Impairment**  | **How does this impact on their General Health and learning?**  |
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| --- | --- | --- | --- |
| **13** | **Hearing** | School Nurse | Parent/Carer |

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| --- | --- |
| **What type of hearing Impairment**  | **How does this impact on their General Health and learning?**  |
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| --- | --- | --- | --- |
| **14** | **Tactile Sensitivity** | School Nurse | Parent/Carer |

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| --- | --- |
| **List Difficulties**  | **How does this impact on their General Health and learning?**  |
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| --- | --- | --- | --- |
| **15** | **Emotional Well-being** | School Nurse | Parent/Carer |

|  |  |
| --- | --- |
| **Title for area**  | **How does this impact on their General Health and learning?**  |
|  |  |
|  |  |
|  |  |
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| --- |
| Are they known to Child and Mental Health Adolescent Services (CAMHS)? **If Yes please give details** |
|  |
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|  |  |
| --- | --- |
| Have they ever been exposed to emotional trauma that may affect their mental health? | Yes No (please explain) |
| e.g. parent dying? |
|  |
|  |
|  |
| **16** | **Self-Harm** | School Nurse | Parent/Carer |

|  |  |
| --- | --- |
| Have there been concerns in the past of threatening to self-harm orperceived self-harming behaviour? | Yes No (please explain) |
|  |
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|  |  |
| --- | --- |
| Have they ever self-harmed? | Yes No  |

Please explain any self-harming incidences

|  |  |  |
| --- | --- | --- |
| **Date** | **Please describe what happened**  | **What was the outcome** |
|  |  |  |
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| --- | --- | --- | --- |
| **17** | **Transitions** | School Nurse | Parent/Carer |

|  |  |
| --- | --- |
| **Item** | **How does this impact on their General Health and learning?**  |
| Changing from one lesson to another |  |
| Moving from one place to another in the same room |  |
| While in the community |  |
| OtherPlease specify |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **18** | **Dressing** | School Nurse | Parent/Carer |

Please tick boxes where the pupil DOES require help.

**Dressing**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Coat  |  | Pants/trousers |  | Socks |  | Footwear |  |
| Jumpers/T-shirts |  | Swimming wear |  | Buttons |  | Zips |  |
| Fasteners |  | Other |  | Other |  | Other |  |

**Un - Dressing**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Coat  |  | Pants/trousers |  | Socks |  | Footwear |  |
| Jumpers/T-shirts |  | Swimming wear |  | Buttons |  | Zips |  |
| Fasteners |  | Other |  | Other |  | Other |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **19** | **Toileting/Hygiene** | School Nurse | Parent/Carer |

|  |  |  |
| --- | --- | --- |
| **Question**  | **Answer Yes/No** | **Please explain in detail** |
| **Do they wear Pads** |  |  |
| **Do they have set times to be taken to the toilet** |  |  |
| **Are they able to indicate they need the toilet** |  |  |
| **Are there only specific toilets they will use** |  |  |
| **Preparation****What do you need to get ready** |  |  |
| **Will you need to give preparation time**  |  |  |
| **Routine****Please state sequence** |  |  |
| **Can they wash their hands** |  |  |
| **Continence Nurse****Involved**  |  |  |
| **Other** |  |  |

|  |  |
| --- | --- |
| Do they require any assistance with hygiene? | Yes No (please explain) |
| Do they have a Hygiene Plan in School at the moment? |
|  |
|  |
|  |
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| --- | --- | --- | --- |
| **20** | **Eating and Drinking Checklist** | School Nurse | Parent/Carer |

Please complete the following check list for signs of possible dysphagia and or choking?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Coughing during or after a meal |  |  | More than once | Often | Always |
| Choking during or after a meal |  |  |  |  |  |
| Chest infections - not accompanied by any other symptoms |  |  |  |  |  |
| Change in voice quality - ‘gurgly’ wet voice |  |  |  |  |  |
| Gasping for breath at mealtimes  |  |  |  |  |  |
| Change of colour in face when eating  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Nasal regurgitation  |  |  | More than once | Often | Always |
| Unusual mealtime level of fatigue  |  |  |  |  |  |
| Difficulty in maintaining a clean mouth  |  |  |  |  |  |
| More time than usual to eat and drink |  |  |  |  |  |
| Recent difficulty in swallowing medication  |  |  |  |  |  |
| Increased drooling  |  |  |  |  |  |
| Pieces of food found in the mouth |  |  |  |  |  |
| Evidence of discomfort when eating  |  |  |  |  |  |
| Recent unplanned weight loss |  |  |  |  |  |
| Unusual sounds when eating/swallowing |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Feeding/Drinking Plan** |  | Written By | Date  | Update Due |
| Is there a drinking/feeding plan in place already ? (attach copy) |  |  |  |  |  |

If the person completing this section has ticked any of the above - advice should be sought from the appropriate member of the Senior Leadership Team.

|  |  |  |  |
| --- | --- | --- | --- |
| **21** | **Signatory Information** | School Nurse | Parent/Carer |

This document has been compiled by …

|  |  |
| --- | --- |
| **Lead Person/Contact (CT/HLTA/TA Etc.)** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Print Name**  | **Title/Role**  | **Signed**  | **Date** |
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**Update Information -**

Please add date where appropriate -

Ensure you are using the most up to date version by checking against the pupils red files.

|  |
| --- |
| **This plan forms part of an EHCP review and must be included in the EHCP review preparation.** |
| **Term 1**  | **Term 2**  | **Term 3**  | **Term 4**  | **Term 5**  | **Term 6** |
|  |  |  |  |  |  |
| **Year**  |  |

|  |
| --- |
| **Please list any further documents that could be referred to** |
| ***Name of Document***  | ***Where found***  |
|  |  |
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| --- |
| **Please list if you have placed parts of this document in specific areas i.e. Kitchen**  |
| ***part of document***  | ***where found***  | ***lead person***  |
|  |  |  |
|  |  |  |
|  |  |  |

**Parents Signature**

**I CONSENT TO MY CHILD RECEIVING EMERGENCY MEDICAL TREATMENT**

|  |  |  |
| --- | --- | --- |
| **Print Name** | **Sign** | **Date** |
|  |  |  |
|  |  |  |

**Please note that it is the parent’s responsibility to inform the school**

**immediately of any change in the child’s details.**

**Audited by School Nurse**

|  |  |  |
| --- | --- | --- |
| **Print Name** | **Sign** | **Date** |
|  |  |  |