

# Administration of Medicines



## Form 1 – Individual Health Care Plan

Child's name

Date of birth

Form

Child's Address

Medical diagnosis or condition

Date

### Family Contact Information – First Contact

Name

Phone Number (work)

(home)

(mobile)

### Family Contact Information – Second Contact

Name

Phone Number (work)

(home)

(mobile)

### Clinic/Hospital Contact

Name

Phone Number

General Practitioner (GP)

Name

Phone Number

Describe medical needs and give details of child's symptoms


Daily care requirements (eg before sport/at lunchtime)


Describe what constitutes an emergency for the child, and the action to take if this occurs


Follow up care


Who is responsible in an emergency (state if different for off-site activities)


Form copies to


**This completed form to be returned to the Welfare Assistant**