

Care plan for children and young people with medical conditions

Name:

DOB:

My condition is

Things you need to be aware of are (i.e. signs and symptoms)

My treatment is

My parent/carer needs to be contacted when

Other information that may be important is

The medicine I need to keep in the Medical room is :(please include details of dosage and frequency

Should there be any changes to my child's care I agree to inform you without delay.

Parent/ guardian
Signature/Date

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Emergency contact address and telephone number of Parent / Guardian

School Nurse use only

Date received Signed

Review date Signed

Date discussed with child/young person Signed