APPENDIX 4: Individual Health Care Plan Template

SECTION 1 OF IHCP *(info completed by establishment)*

Individual Health Care Plan (IHCP)

Insert photograph of individual here

Name:

Date of Birth:

Reason for IHCP:

Name of Establishment:

Plan start date:

Plan review date:

Travel arrangements	*Delete as appropriate*
1. Walking: alone or in group	yes/no
2. Parent / carer transport	yes/no
3. SBC contract travel (e.g. bus, taxi etc)	yes/no
4. SBC escorted travel	yes/no
5. Other: please specify	yes/no

Additional information re travel arrangements:

Link to online document/templates and resources
www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/children-young-peoples-services-directory/multiagency-administration-of-medicines-for-c-and-yp/

SECTION 2 OF IHCP *(info provided by parent and inserted by establishment)*

Name of medical condition and summary of help that individual needs

SECTION 3 OF IHCP *(info provided by parent and inserted by establishment)*

Contact numbers

Name		Relationship/role	Tel no.
1			
2			
3			
4			
5			

SECTION 4 OF IHCP *(info provided and signed by health professional)*

Details of diagnosed condition/health care procedure or medication required / emergency procedures

Attach plan for anaphylaxis, asthma, epilepsy or other to the IHCP – to be provided and signed by health professional (e.g. paediatrician, nurse specialist)

For children with diabetes the Diabetic Specialist Nurses will provide a specific IHCP

SECTION 5 OF IHCP: Signatures / Agreement to Individual Health Care Plan

Signatory	**Name / Role** (please print)	**Signature**	**Date**
Head			
Parent / Carer			
Young Person (Optional if appropriate)			

(Note: signature from health professional provided as part of Section 4)

Original document to be retained by Head

Copies sent to:

- **Parents/Carers**
- **Health Professional(s)**
- **Other professionals**

Record of staff training to be held separately by Head of Establishment

Link to online document/templates and resources
www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/children-young-peoples-services-directory/multiagency-administration-of-medicines-for-c-and-yp/

SECTION 3 OF IHCP: FLOW CHARTS / EMERGENCY PROCEDURES

To be completed by health professional

RECOGNITION OF SIGNS/SYMPTOMS AND MANAGEMENT OF SEVERE ALLERGIC REACTION (ANAPHYLAXIS)

Name: ..... **DOB:** ...../...../.....

Allergic to .....

Previous symptoms:

-
-
-

Recognition of Anaphylaxis, i.e. following three criteria are fulfilled

1. Skin and or mucosal changes (flushing, urticaria, angioedema)
2. Sudden onset and rapid progression of symptoms
3. Life threatening Airway and /or Breathing and /or Circulation problems

AIRWAY	BREATHING	CIRCULATION
Hoarse	Irregular	Hot and flushed
Itchy or swollen throat	Wheezy	Pale or clammy
Swollen tongue	Noisy	Decreased conscious level
	Can't speak	Blue round mouth

Do not administer adrenaline on the basis of an isolated skin rash.

Prescribed Adrenaline Auto-Injector (specify EPIPEN and dose)

.....

Immediate Action

- **Detect Symptoms – Alert appropriate staff member.....**
- **Administer Auto - injector into patients upper outer thigh**
- **Stay with patient at all times**
- **May be more comfortable in an upright position to aid breathing**
- **If unresponsive place patient in the recovery position**
- **If no improvement in 5 minutes, give second Auto - injector**

At the same time as above another staff member must phone 999 Ambulance

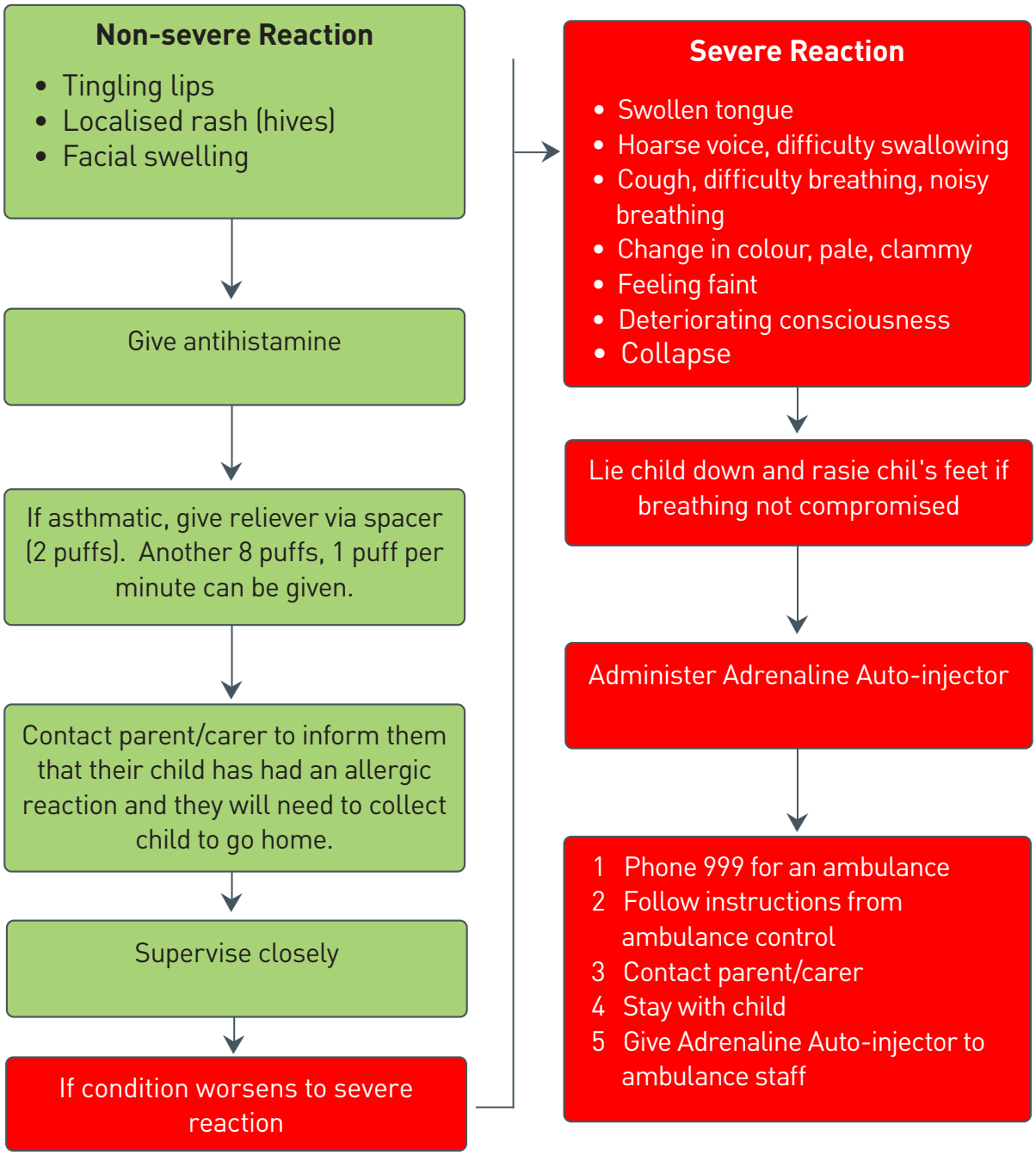
Stating Anaphylaxis and location

Link to online document/templates and resources
www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/children-young-peoples-services-directory/multiagency-administration-of-medicines-for-c-and-yp/

Secondary Action: Parents should be phoned ASAP.

Parents Number	**Emergency contact** (if parent unavailable)
Home	Home
Work	Work
Mobile	Mobile

ACTION PLAN:



Link to online document/templates and resources
www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/children-young-peoples-services-directory/multiagency-administration-of-medicines-for-c-and-yp/

SECTION 4 OF IHCP: CONTACT NUMBERS AND FURTHER INFORMATION ABOUT ANAPHYLAXIS

General Practitioner:

Name: ..... Tel:-.....

Parents / carers number:..... Home.....

Work .....

Other/ Mobile/s .....

Emergency Contact *(alternative) .....

*If parent / carer unavailable.

School Nurse / other health professionals:

Name/title ..... Tel:-.....

Name/title ..... Tel:-.....

Useful websites

www.anaphylaxis.org.uk
www.allergyfoundation.com (British Allergy Foundation)
www.allergyuk.org
www.allergyinschools.org.uk
www.epipen.co.uk

SECTION 5 OF IHCP: ADDITIONAL INFORMATION

It is the responsibility of parents / carers to maintain in date medication

Include following information if relevant on an individual basis

The establishment should take all reasonable steps to ensure that the child/young person does not eat any foods other than those approved by the parents.

Parents/carers will provide suitable food to meet the child or young person's needs on a daily basis (including mid-morning snack, packed lunch and suitable sweets).

Parents/carers must remind their child regularly of the need to refuse any food items which might be offered by other children.

Link to online document/templates and resources
www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/children-young-peoples-services-directory/multiagency-administration-of-medicines-for-c-and-yp/

SECTION 6 OF IHCP: RECORD OF TRAINING FORM

Please enter name of procedure and details of the training provided to carry out the procedure.*

* To be completed by the trainer

The persons listed below have received training in the above procedure(s to detect, recognise and competently respond to the symptoms that require administration of medication or health care procedure to be carried out.

Name (print)	Signature	Date of training

Training delivered by:

Name (print)		Signature	Date
1			
2			

Training designation (E.g. school nurse; diabetes specialist nurse etc)

1	
2	

The trained persons shown above have been accepted to carry out the above named procedure	
Head Signed: (print name)	
Establishment:	
	Date:

Link to online document/templates and resources
www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/children-young-peoples-services-directory/multiagency-administration-of-medicines-for-c-and-yp/

SECTION 7 OF IHCP: Signatures / Agreement to Individual Health Care Plan

Individual's Name: _____ (Print)

Date of Birth: _____ (dd/mm/yyyy)

Establishment: _____

Plan start date: _____ (dd/mm/yyyy)

Plan review date: _____ (dd/mm/yyyy)

The content of this Individual Health Care Plan has been agreed by the undersigned

Signatory	Name / Role (please print)	Signature	Date
Head			
Health Professional(s) (minimum of one signature required)	Name: Role:		
	Name: Role:		
	Name: Role:		
Parent / Carer			
Young Person (optional if appropriate)			

Original document to be retained by Head

Copies:

- **Parents/Carers**
- **Health Professional(s)**
- **Other professionals (e.g. Integrated Children's Services, Named Person, Lead Professional)**
- **Senior Education Office (SBC only)**

Note to health staff: copy of plan should also be kept in child/young person's BGH record

Link to online document/templates and resources
www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/children-young-peoples-services-directory/multiagency-administration-of-medicines-for-c-and-yp/