**Logo

Description automatically generatedCare Plan Contextual Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Child’s Name: |  | | | | | **Photo** |
| Group/class/form: |  | | | | |
| Date of birth: |  | | | | |
| Child’s address: |  | | | | |
| Medical diagnosis/condition: |  | | | | |
| Date: |  | | | | |
| Review date (Year 1): |  | | | | | |
| Review date (Year 2): |  | | | | | |
| **Parent / Carer Contact details** | | | | | | |
| Parent/Carer 1: | | | | |  | |
| Phone No. (Work): | | | | |  | |
| Phone No. (Home): | | | | |  | |
| Mobile No : | | | | |  | |
| Relationship to child: | | | | |  | |
| Parent/Carer 2: | | | | |  | |
| Phone No. (Work): | | | | |  | |
| Phone No. (Home): | | | | |  | |
| Mobile No.: | | | | |  | |
| Relationship to child: | | | | |  | |
| **Clinic/Hospital Contact** | | | | | | |
| Name: | | | |  | | |
| Phone No: | | | |  | | |
| **General Practitioner (GP)** | | | | | | |
| Name: | | |  | | | |
| Phone No: | | |  | | | |
| Who is responsible for providing support in school | |  | | | | |
| **Type(s) of Plan Required** | | | | | | |
| Health & Medical (medical condition(s), other than asthma and an allergy)  Prescribed Medication  Intimate Care  Allergy Action Plan  Asthma | | | | | | |