Phoenix Football Club
Individual Healthcare Plan

Child's name					
Team and age group					
Date of birth					
Child's address					
Medical diagnosis or condition (s)					
Family Contact Information					
Name					
Main Phone no.					
Name					
Relationship to child					
Main phone no.					
Relationship to child					
Clinic/Hospital Contact *(if applicable)*					
Name					
Phone no.					
G.P.					
Name					
Phone no.					

Name of key person responsible in the team (coach)	

Describe the child's medical needs and give details of symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Other information

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

Who is responsible in an emergency?

Plan developed with (name of parent)

Staff training needed / undertaken – who, what, when?

Form copied to

Phoenix Football Club
Individual Healthcare Plan
Parental agreement for setting to administer medicine

The coaches for the club will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Date for review to be initiated by	
Name of team and age group	
Name of child	
Date of birth	
Medical condition or illness	
Medicine	
Name / type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions / other instructions	
Are there any side effects that the club need to know about?	
Self-administration – y / n?	
Procedures to take in an emergency	
NB: Medicines must be in the original container as dispensed by the pharmacy **Contact Details**	
Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff]

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) Date

Record of medicine administered to an individual child

Name of team and age group	
Name of child	
Date medicine provided by parent	/ /
Quantity received	
Name and strength of medicine	
Expiry date	/ /
Quantity returned	
Dose and frequency of medicine	

Staff signature
Signature of parent

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			
Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									
Date									
Time given									
Dose given									
Name of member of staff									
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Date									
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Dose given									
Name of member of staff									
Staff initials									
Date									
Time given									
Dose given									
Name of member of staff									
Staff initials									

Training record – administration of medicines

Name of team / age group				
Name				
Type of training received				
Date of training completed				
Training provided by				
Profession and title				

I confirm that [name of coach] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [name of coach].

Trainer's signature

Date

I confirm that I have received the training detailed above.

Coach signature

Date

Suggested review date