Allergy - Individual Healthcare Plan	
Name: **Date of birth:**	**Picture:**
Emergency Contact: **(name and relationship/s)**	
People who need to be aware:	
Information Sharing: Permission is granted for this information to be shared with anyone who needs this information to keep my child safe.	
Date issued: **Next Review:**	**Last discussed with parents:**
Allergy:	

Medical Condition:
(please detail the allergy and history of any reactions)

How the condition is managed:

How the condition affects their education:
Impact on health:

Impact on Learning:

Impact on well-being:

How the condition affects their life:

Considerations required at meal and snack times:

School Arrangements to support your child:

Medication:

Awareness:

Curriculum:

Training:

School environment:

Visits:

Emergency Response:	
Is the child aware of their health worsening and can they alert an adult?	
Pupil's Comments (if appropriate):	
Name of adult completing Form: **Relationship to child:** **Date:**	**Signed:** *Joanne Randall* **Date:**
Parent/Guardian/Carer	**Assistant Headteacher/DSL**
Signature (to be signed in person)	