

General Health Care Plan

This plan should be completed jointly with the parent/carer and young person (if appropriate). It should be used in addition to the relevant Girlguiding UK forms, eg Starting Rainbows/Brownies/Guides/Senior Section, G/C (consent form), G/H (health form) and the one day activity form (G/O). It is designed to ensure you have sufficient information to manage the young person's health condition during meetings, on outings, residential events, etc. It is important that the plan is reviewed regularly to ensure it is up to date. If you feel you require further information/training/advice please contact your Commissioner or County/Region Special Needs Adviser. Please note it may be more appropriate to use the specific health care plans for diabetes, epilepsy, asthma and severe allergies/anaphylaxis.

Name of young person: _____ Date of birth: _____

Address: _____

Condition(s): _____

Date of health care plan: _____ Review date: _____

Contact information

Name _____

Relationship _____ Phone No. _____

Name _____

Relationship _____ Phone No. _____

Clinic/Hospital/GP contact (consultant/nurse specialist/ward) if applicable

Name _____ Phone No. _____

Name _____ Phone No. _____

GP _____ Phone No. _____

Describe the girl's condition and individual symptoms

Daily medication requirements:

Any other special requirements:

What constitutes an emergency?

What action should be taken in an emergency?

Emergency medication requirements including dosage:

Where is medication to be kept?

Who can administer the medication?

Leader/first aider's signature(s):

Parent/Young person's signature:

Health Care Plan for Treatment of Severe Allergy/Anaphylaxis

Name _____ Date of birth _____ May suffer from an allergic or anaphylactic reaction if she eats or comes into contact with _____

Signs and symptoms of a severe allergic reaction include:

- wheeziness
- breathing difficulties
- skin rash
- itchy skin
- drowsiness
- pallor or flushing of skin
- swollen and/or blue lips
- collapse
- other (list)

Emergency treatment depends on severity of the reaction:

Mild/moderate reactions (delete this section if not applicable to the young person above)

Symptoms/signs of a mild reaction: itching of skin, rash, swelling/puffiness of eyes, tickly throat, tummy ache, nausea, (circle those applicable), other (list) _____

Give antihistamines in the form of _____ syrup/tablets immediately (insert name and dose of medication).

If there is no improvement, or reaction gets worse, seek medical help and follow instructions in box below.

Severe reactions/anaphylaxis

A reaction is severe when there is:

- difficulty breathing, wheezing or a choking feeling
- swelling of mouth, lips, tongue with difficulty swallowing/talking
- drowsiness, floppiness, collapse or deteriorating consciousness.

1. Send someone to call an ambulance immediately (999). Tell ambulance control this is a case of **anaphylaxis (ana-fi-la-xis)**.

2. If the child has an EpiPen/Anapen administer the dose into the outer side of the thigh midway between the knee and hip. Note time of administration _____

3. Call the parents _____ Tel _____

4. Monitor the child's condition AIRWAY, BREATHING, CIRCULATION (ABC) and if worse after 5–10 minutes give second dose of EpiPen (if available) while waiting for the ambulance to arrive.

5. If the child/young person becomes unconscious at any time, place in the Recovery Position and continue to monitor airway, breathing and pulse. If necessary commence CPR.

NOTE TO PARENTS Leaders who agree to administer an EpiPen/Anapen are encouraged to obtain appropriate training from a health care professional on anaphylaxis and the use of adrenaline autoinjectors.

Medication must be clearly marked with child's NAME. It is the parent's responsibility to ensure that the medication is checked and in date, and replaced as necessary. The EpiPen/Anapen should be carried by the person at all times but when on camp/holiday it is advisable to have a spare EpiPen/Anapen available in the remedy box.

Signature of parent/carer _____ Date _____

Signature of Leader(s) _____ Date _____

Signature of Leader(s) _____ Date _____

Date plan to be reviewed:

This form is in addition to the Girlguiding UK Health form (G/H) or One day activity form (G/O)

Health Care Plan for Epilepsy/Management of Seizures

Name: _____ Date of birth _____

Name of medication	Dose	Time given

Possible triggers to a seizure

Brief description of the usual pattern of seizures (continue on a separate sheet if necessary)

Action to be taken if a seizure occurs

NOTE TO PARENTS – if use of rectal diazepam or buccal midazolam is required, Leaders who undertake this duty will need to receive appropriate training from a healthcare professional.

When to call an ambulance:

- If the seizure lasts longer than _____ minutes.
- If one seizure is directly followed by another seizure.
- If the person is injured during the seizure.

Name of Leader(s) trained and authorised to give rectal diazepam/buccal midazolam (delete as appropriate).

Leader's name _____ Date _____

Leader's name _____ Date _____

I give my permission for those named above to administer emergency medication to me/my child.

Signature of parent/carer/member _____ Date _____

Signature of Unit Leader/first aider _____ Date _____

Date plan to be reviewed:

This form is in addition to the Girlguiding UK Health form (G/H) or One day activity form (G/O)

Health Care Plan for Asthma

Name of child/young person _____ Date of birth _____

TYPE OF INHALER	Name and colour	Dose/number of puffs	When to be given
Preventer inhaler			
Reliever inhaler			
Any other inhaler			
Any other medication			
Emergency medication			

When going on camp/holiday it is always advisable to take a spare reliever inhaler which is kept by the first aider or Unit Leader.

Action Plan

My normal PEAK FLOW readings are _____. These are an indication of how well controlled my asthma is.

If they fall below _____ or my symptoms (cough, wheeze, breathlessness, tight chest) get worse I need to _____

If I have symptoms all the time or I have to take my reliever inhaler regularly through the day or my peak flow readings fall below _____, I need to _____

I need to avoid the following because they may trigger my asthma: _____

An emergency situation is when:

- my reliever inhaler does not help my worsening symptoms
- I am too breathless to speak.

What to do:

- continue to use the reliever inhaler (use a spacer device if you have one)
- dial 999.

Signature of parent/carer/member _____ Date _____

Signature of Unit Leader/first aider _____ Date _____

Date Plan to be reviewed: _____

If the young person already has a personal asthma plan you should continue to use it.

Health Care Plan for Diabetes

Name _____ Date of birth _____
has diabetes and needs insulin injections /tablets to control her blood sugar level.

Current treatment

Name of medication/Insulin type	Dose	Time to be given

It is important that she has regular meals and snacks at the times below:

Meal times	Snack times	Suggested snacks
Breakfast	Morning	
Lunch	Afternoon	
Dinner	Evening	

It is also important that before any vigorous activity/exercise she has an additional snack of:

Blood testing should be done at the following times of day: _____

Normal blood glucose levels for _____ are _____

Hypoglycaemia

Typical symptoms for _____ are _____

Provided she is conscious and able to swallow, fast acting sugar should be given immediately, eg fruit juice, Lucozade, sugary drinks including Coke, Tango, Fanta (not sugar-free versions), three or more fresh glucose tablets, honey or jam.

For _____ give _____

If she is too drowsy or confused to eat or drink or help herself, rub some jam, honey or GlucoGel inside the cheek where it can be absorbed.

When she has recovered, follow up with starchy food such as two biscuits and a glass of milk or a sandwich. Do not leave her alone until she has fully recovered from the hypo. This usually takes _____ minutes. If she becomes unconscious DO NOT give her anything by mouth. Place her in the Recovery Position and call an ambulance.

Signature of parent _____ Date _____

Signature of Unit Leader/first aider _____ Date _____

Date plan to be reviewed:

Note: Additional information regarding adjusting insulin doses according to blood glucose levels should be firmly attached to this health care plan.