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**MEDICAL FUNDING GUIDANCE**

A medical need is not necessarily a special educational need or disability and schools will be experienced with children with a variety of requirements. Schools are expected to make arrangements to help the child manage their condition and overcome any potential barriers to getting the most from their education.

Medical funding is available for school age children and young people whose needs have changed significantly due to medical reasons. It is used to ensure consistency of access to education.

The Local Authority will consider providing funding as an interim measure; it is expected that ultimately the child or young person will be able to resume access to their educational environment.

In the event that barriers to accessing education remain after the allocated period, re-submission will be required.

* This information is sought in accordance with the Children and Families Act 2014 and the statutory guidance ‘Supporting pupils at school with medical conditions**’**
* Early Years settings should apply the Statutory Framework for the Early Years Foundation Stage.

In the first instance, all educational settings are required to use their best endeavours to meet the needs of children and young people.

Please provide evidence of the following:

1. Description of the child or young person’s current medical needs
2. Care Plan devised with relevant health professionals
3. Up to date medical reports evidencing the requirement for the medical provision outlined in the Care Plan
4. Costed Provision Map evidencing use of school’s delegated funding
5. The outcomes sought for the child or young person
6. Details of the additional support which is required and cannot be provided through delegated funding

All medical funding requests will be considered by the Inclusion Allocation Panel.

**Medical Funding Request Form**

**Child or Young Person’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name:  |  | Educational Setting: |  |
| Unique Pupil No: |  | Type:  | Maintained/Special/Private/Academy/Free/Non Maintained  |
| Ethnicity: |  | SEN Status: |  |
| Date of Birth: |  | Year Group:  |  | Key Stage:  |  |
| Child/Young Person’s Address:  |  |
| Child/Young Person in care | Yes/No (delete as appropriate)  | Home Authority: |  |
| Parent/Carer Name:  |  | 2nd Parent/Carer Name: |  |
| Relationship:  |  | Relationship: |  |
| Parent’s Address (if different):  |  | Parent’s Address (if different): |  |
| Phone number: |  | Phone number: |  |

**Current Attendance Record –** *please provide as much information as possible*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Educational Setting**  | **Period (Dates)** | **Actual Attendance** **No of sessions**  | **Possible Attendance** **No of sessions**  | **Percentage Attended**  |
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**Section A:**

**Description of the child/young person’s current medical needs**

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**Are there any relevant factors in relation to the child or young person’s medical needs?**

e.g. home circumstances, social relationships. If the answer is yes, please provide below or attach copies of relevant documents

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**Section B:**

**Professional Involvement: list details of attached reports/evidence from appropriate services.**

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| --- | --- | --- | --- |
| **Service provided by (Name and Role )**  | **Date of Reports**  | **Date Assessed**  | **Brief Description of Evidence Provided**  |
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**Section C:**

Details of the current support and reasonable adjustments made. Please attach the current Healthcare Plan.

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| --- | --- | --- | --- | --- | --- |
| **Reasonable Adjustments made**  | **Frequency and Duration**  | **Delivered by** | **Start Date** | **Review Date** | **Outcomes (Achieved, Partially Met, Not Met)**  |
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**Section D:**

**Medical Funding: What outcomes are you hoping to achieve for the child/young person? This information can be provided on a provision map**

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| --- | --- | --- | --- | --- | --- | --- |
| **Outcomes sought**  | **Type of Provision** | **Objective of provision**  | **Frequency and duration**  | **Delivered by** | **Start Date** | **Review Date** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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**Details of the additional support required which cannot be provided through delegated funding:**

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| --- |
|  |

**Request authorised by:**

|  |  |
| --- | --- |
| **Signature:**  | **Name:**  |
| **Title:**  | **Date:**  |
| **Contact Telephone number:** | **Contact Email Address:**  |

**Please return this form by secure email to the Inclusion Allocation Panel: additionalneedsteam@bury.gov.uk**