**MEDICAL FUNDING REVIEW FORM**

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| --- | --- | --- | --- | --- |
| **Date of the review:** | | |  | |
| **Name** |  | **Address** | |  |
| **D.O.B** |  | **Setting** | |  |
| **Ethnicity** |  | **SEN Status** | |  |
| **Year Group** |  | **Attendance** | |  |
| **Name of person with parental responsibility** |  | | | |
| **Relationship** |  | | | |
| **Address** |  | | | |
| **Contact no** |  | **Contact no** | |  |
| **e-mail** |  | **e-mail** | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Attendance at review meeting** | | | | |
| **Name** | **Role** | **Contact details** | **Attended meeting** | **Sent advice/report** |
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| **Summary of the child’s current medical needs and the impact in school** |
|  |
| **How is the medical funding being used to meet the child’s needs?** |
|  |
| **Has there been any significant change to the child’s medical needs over the last 12 months?** |
|  |
| **What steps is school taking in trying to increase the child’s independence in managing their medical condition?** |
|  |
| **Please confirm the steps to develop independence are agreed by parents, health professionals and school.**  **Yes No** |
| **If no please state the reasons.** |
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| --- | --- | --- | --- |
| **Other service involvement** | | | |
| **Name** | **Service** | **Contact Details** | **Dates of involvement** |
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| **Recommendation from the review** | | |
| **Recommendation** |  | **Any additional information** |
| Maintain the medical funding with no changes |  |  |
| Decrease in funding to recognise independence |  |  |
| Medical funding is no longer required |  |  |
| An increase in funding is required |  |  |

|  |  |
| --- | --- |
| **Signature** | |
| **Name:** | **Position:** |
| **Signature:** | **Date:** |
| **Date submitted to the LA:** |  |

|  |  |
| --- | --- |
| **Please return to the Inclusion Allocation Panel within two weeks of the date of the review meeting. Please ensure you attach:** | |
| Care Plan devised with relevant health professionals |  |
| Up to date medical information evidencing the requirement for the medical provision outlined in the Care Plan |  |
| Costed Provision Map evidencing use of school’s delegated funding and use of previous Medical Funding |  |
| Views of parent, pupil and other professionals |  |

**Please return to the Inclusion Allocation Panel by e-mail to** [**additionalneedsteam@bury.gov.uk**](mailto:additionalneedsteam@bury.gov.uk)