Modular file for foster carers

Fostering be the difference

Wiltshire Council
Where everybody matters

Recording Policy in Foster Care

National Minimum Standards (Fostering Services) 2011

OUTCOME
Records are clear, up to date, stored securely and contribute to an understanding of the child's life.

STANDARD 26

26.1 The fostering service has and implements a written policy that clarifies the purpose, format and content of information to be kept on the fostering service's files, on the child's files and on case files relating to foster carers.

26.2 Fostering households understand the nature of records maintained and follow the fostering service's policy for the keeping and retention of files, managing confidential information and access to files.

26.4 Information about individual children is kept confidential and only shared with those who have a legitimate and current need to know the information.

26.6 Information about the child is recorded clearly and in a way which will be helpful to the child when they access their files now or in the future. Children are actively encouraged to read their files, other than necessary confidential or third party information, and to correct errors and add personal statements.

26.7 The foster carer understands the important supporting role they play in encouraging the child to reflect on and understand their history. The child is encouraged to keep memorabilia (including photographs) of their time in placement. The fostering service makes this role clear to their foster carers and ensures they can record, and help children make a record of, significant life events.

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Guidance for foster carers:
The fostering service requires you to keep information on, and complete records about, any child you are caring for. There are a number of reasons why information and recording is important when looking after someone else's child. These are as follows:

- As corporate parents, carers are accountable for the children in their care;

- It is unlikely, for those caring for someone else's child, that they will keep all key information in their head, in the same way that birth parents usually do;
- It is an expectation that all foster carers keep a modular file on the child/ren in their care, which includes all essential information which enables them to care for the child safely;
- An up-to-date file kept by the foster carer for each child in their care demonstrates the work they do in their professional role as foster carers and provides evidence for progression/development/skills appraisal etc;
- Everyone involved in looking after someone else's child is responsible for keeping good records which are legible, clearly expressed, non stigmatising, distinguish between fact and opinion and third party information and are signed and dated;
- Children in care should have a written record of the time they spend in care which records the child's progress and development and significant events in their life. For this reason, key records should be maintained by those looking after them;
- Records protect carers in terms of demonstrating their responsibilities, accountabilities, responses to events and actions;
- Records provide key information and contribute to planning for children;
- Records provide key information for new carers when a child moves placement;
- Records belong to the child and should move with them to their new carers then maintained on the child's file when they leave care. Children's social workers and fostering social workers should ensure this happens
- Files will be reviewed within carer's supervision sessions to ensure the quality and adequacy of record keeping is monitored and to ensure support is provided to improve the quality where needed;
- Diary sheets will be read and signed by your fostering social worker during supervision and should be shown to the child's social worker throughout the placement;
- Records on diary sheets about day-to-to day events, as a matter of good practice, should be shared with the children in placement. Children should be actively encouraged to enter their own notes alongside the carers.
- Diary sheets should as a general rule be completed daily (although in discussion with your fostering social worker weekly diary sheets may be agreed in some circumstances e.g. long term placements) and include details of: significant events and notable incidents in the child's life both at home, school and elsewhere; illnesses, injuries and accidents; positive behaviour and any areas of concern; doctors, dentist and opticians appointments; details of immunisations and all medication or

medical treatment give; contact with birth family; contact with the department and other professionals

- Any significant incident or event should be written up within 24 hours and reported to your fostering social worker. An incident report form should be completed and reported to your fostering social worker in any of the following circumstances: any incidents where you have physically restrained a child in your care; a safeguarding incident involving a child in your care; a child missing from foster care; serious illness or accident of a child placed with you; outbreak of a notifiable infectious disease within your home; allegation that a child placed with you has committed a serious offence; involvement or suspected involvement of a child placed with you in prostitution; serious incident involving a child placed with you which results in the police being called to your home;
- Files for each child in care should be securely stored in a lockable drawer/container/cabinet and only shared with those who have a legitimate need to know the information

What should be kept within a foster care modular file?
Clear guidance are contained within the modular file.

Storage of Files
All children's files kept by foster carers should be stored securely in a lockable container / cabinet.

Modular Files for Children in Foster care

What is the purpose of the modular File? The purpose of the Modular File is for foster carers to hold and record information regarding individual foster children. A file will be issued at the start of a placement in order to keep information held separately and individually for each child. At every supervision session your Supervising fostering Social Worker will go through your modular file(s) with you. At the end of the placement the file should be returned to your Supervising Social Worker, who will bring the file back to the office and the information will then be forwarded on to the young person's Social Worker. This file will also be of use during Regulatory Inspections, providing key evidence indicators to inspectors.

A BIT OF GUIDANCE

See the File Structure Sheet which lists what forms should be kept in each section of the file. For some additional information, please see below:

Section 1

This section is for filing all key information regarding the child/young person you are looking after. Some information will come from the social worker for the child and some will be added by yourself, for example, key names and addresses.

Any Risks Assessments and safe caring assessments should also be filed in this section. Your Supervising Fostering Social Worker will go through the Safe Caring Policy with you and a copy of the Safe Caring Policy, drawn up at the start of the placement should be filed in this section.

Section 2

This section tends to be the section where you log copies of important documentation that you receive from the Social Worker for the child in your care. It includes essential information about their care and copies of the care plan and placement plan (which you will have been involved in formulating) for your day to day guide

Section 3

A stock of blank Diary Sheets will be in this section and you should record information about the child on these sheets. As a general rule diary sheets should be completed daily, but only must be used when there is something important to record. This could be something that is really positive about behaviour or an achievement for example. Records of difficulties should also be recorded – basically anything significant. Be guided by the fact that this is a record of a child's time in your care so don't record for the sake of it, but ensure you capture all significant occurrences, including when they have contact with their family and any issues that occur as a result of the contact. These are all important factors to capture. You may just wish occasionally to say that s/he has been really good and that they're doing well. Ensure there are no major gaps in these records, e.g. there should be something to say at least every week. Also encourage the child/young person to add their views and comments to their records, alongside your entries.

NB: If you require additional sheets, this can be arranged via your fostering social worker. Or they could be emailed to you – whichever you prefer.

Evidence Sheets for the work you are undertaking to meet the 5 outcomes and to demonstrate your professional development will also be provided in this section. You can use these with your supervising Social Worker during supervision.

Section 4

This is the legal section and the list of forms /documents that may be filed in this section is listed on the file structure document.

Section 5

This section should contain minutes of meetings. This may be planning meeting minutes and minutes from statutory reviews, especially important to keep if there are specific action for carers to take. Ask for copies of these minutes if you do not get them routinely.

Section 6

This section is for Foster Carers to file away any correspondence. This could be letters or faxes. If you have emails relating to a child in your care, print them off and file them in this section, then delete them from your computer/laptop. You should not keep any emails/information on your personal computer about a child after they have left your care.

Section 7

This section is for confidential information. It is not intended to store information here that purely relates to something you think a child in your care should not know. It is broadly to store information that comes from a third party which has not yet been shared, e.g. information from health personnel. It is unlikely that a foster carer's modular file has information to store in this section. Any important information will be communicated via the child's social worker. Please ask your fostering Social Worker for advice if you need advice.

Section 8

This is a log of significant events, e.g. Incident Report Forms – there is a stock of Forms within this section, which should be completed as necessary. Original completed forms should be sent to your fostering social worker ASAP. NB: If you require additional sheets, this can be arranged via your fostering social worker.

An End of Placement Report will be provided in this section – **At placement end, Foster Carers should complete this Report and pass the whole file to their Supervising Social Worker, who will, in turn, return it to the office.**

Section 9

This section is for Foster Carers to file away any educational information / school reports / achievement certificates etc about the child in placement. It is also important to keep a record of educational information such as absences, achievements etc.

Section 10

This is the section where you should record all information relating to the health the child in your care. The File Structure sheet logs the forms that should be logged here.

File Structure: Fostering

Section	Content
1	**Key Information:** Key Names & Addresses Risk Assessment Individual Safe Caring Strategy Essential & Statutory Documentation – checklist
2	**Departmental Administration:** Placement Information Placement Referral Form Placement Plan including delegated authority <u>Guidance Documents re Delegated Authority:</u> Decision Support Tool Information for Parents of Children in Foster Care Care Plan Pathway Plan
3	**Recording:** Diary Sheets 5 Outcomes Evidence Sheet
4	**Legal:** Copies of birth certificates Emergency Protection Order/Interim Care Order/Care Order if applicable Charge sheets & bail conditions etc.
5	**Reviews:** Initial Planning Meeting Minutes Placement Planning Meeting Minutes Minutes of Looked after Children Reviews
6	**Correspondence:** Letters and faxes, e-mails
7	**Confidential:** Third Party Information, e.g. Child Protection Documentation Psychiatric/Psychological Reports
8	**Significant Events Notifications/ Incident Reports** **End of Placement Reports**
9	**Education:** Young Persons Education Record Statement of Education Needs Personal Education Plan (PEP) Education Report/Assessment External Educational Reports
10	**Health:** Consent for medical treatment form Personal Health Plan Health Diary Sheet Medical Information and Medication Recording Form

Child/Young Person's Name: ....

KEY NAMES AND ADDRESSES

Name: Relationship to child/young person: Address: Telephone Number: Correct at:	Name: Relationship to child/young person: Address: Telephone Number: Correct at:
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ESSENTIAL AND STATUTORY INFORMATION/DOCUMENATION

(Required by Carers for every Looked After child)

Name of Child				
Care First Number				
Date of Birth				
Date Placement Started				
Date Placement Ended (if applicable)				
Name of Foster Carers				
Was Placement Planned?	YES		NO	

Documentation/information to be checked by Fostering Supervising Worker at supervision sessions. Any missing information must be obtained from the child's Social Worker. Failure to obtain information required by foster carers to be escalated to Child Care Team Manager/Fostering Manager. Fostering Supervising Social Worker to ensure updated information is provided to foster carers as required.

This form should be kept on the child's modular file and placed on the Carer's file after the placement has ended.

INFORMATION/DOCUMENTATION RECEIVED (other information may be provided and should be added to the table)	**YES**	**NO**	**DATE PROVIDED/ COMMENTS**	**DATED UPDATED**
Placement Request Form				
Risk Assessment for Child				

<u>INFORMATION/DOCUMENTATION RECEIVED</u> (other information may be provided and should be added to the table)	**YES**	**NO**	**DATE PROVIDED/ COMMENTS**	**DATE UPDATED**
<u>Placement Plan</u>				
Is it clearly outlined within the Placement Plan who can give agreement for: *medical and dental treatment* *education* *leisure and home life* *faith and religious observance* *use of social media* *and any other matters considered relevant* in relation to the child (delegated authority)				
<u>Essential Information including:</u>				
Child's name, dob, home address				
Legal status of child inc who has PR				
Reasons why child is Looked After				
Expected duration of placement				
Child's understanding of why they are Looked After				
Wishes and feelings of the child				
Contact details of parents				
Contact details of significant family members				
Contact details of GP and Health Visitor				
Contact details of school/nursery				

Contact details of child's Social Worker				
Contact details of IRO				
Contact details of EDS				
Essential health information including medication, allergies, disabilities, developmental issues, mental health issues and any planned health appointments				
Information regarding the child's routines and situations where the child may have difficulties coping				
Any safeguarding issues that need to be considered				
Contact arrangements and any person who should NOT have contact and the reasons why				
Medical Consent Form				
Care Plan				
Copy of Birth Certificate if applicable				
Legal Orders/Parental Consent for Accommodation				
Individual Safer Caring Strategy for this child in placement				
LAC Review				
Permanency Plan / Pathway Plan				

PEP				
Health Plan				

Signatures:

Parent:		Date:
Carer		Date:
Child's Social Worker		Date:
Fostering Social Worker		Date:

the fostering network
the voice of foster care

Delegated Authority
Decision Support Tool

This *Decision Support Tool* is to assist social workers, parents, foster carers and young people to talk to each other about delegated authority. It can help to prepare for the initial Placement Planning meeting and each subsequent review when the Placement Plan is considered. It is an aide to good practice in working with delegated authority. **It does not replace or replicate the Placement Plan, which is the legal requirement for this purpose. The required content of the Placement Plan is set out in Schedule 2 of the Care Planning, Placement and Case Review Regulations 2010; relevant statutory guidance is in Chapter 2 of the Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review**.

The *Decision Support Tool* is supported and explained further in the Fostering Network's handbook *Supporting Placement Planning*. It is based on consultations which suggest that the areas covered are those where it is particularly important to have clarity. The aims are to ensure that the Placement Plan:

- is viewed as a living document that can change over time
- covers all the areas necessary for every child
- is as clear and inclusive of parents and foster carers as possible.

The *Decision Support Tool* is not a definitive list of tasks and responsibilites: over the life of a child's placement with foster carers, other areas will inevitably arise and require clarification and not all of the elements that are included will apply to every young person. In addition to preparing for planning meetings and reviews, its other uses are:

- To assist supervising social workers to prepare fostering applicants for the tasks in foster care and to assess their needs in relation to the *Training, Support and Development Standards for Foster Care*.
- For child care social workers to use with parents who need additional support to understand delegated authority. The leaflet *Information for Parents about Delegated Authority* may also help with this.

Clarifying who is best placed to take everyday decisions depends on many factors: the young person's age, views, legal status and care plan, the parents' views and the experience and the views of the foster carers. Collaboration and consultation are essential for successful partnership working.

Child/young person _____

1. Medical and Health

Consent/agreement/task	Who has authority to give consent/agreement or undertake the task [1]	Notes (inc. notifications, prior consultation /recording requirement/conditions)	Date
1.1 Signed consent to emergency medical treatment (incl. anaesthetic)			
1.2 Consent – routine immunisations			
1.3 Planned medical procedures			
1.4 Medical procedure carried out in the home where the person administering the procedure requires training (eg child with disability/illness)			
1.5 Dental – signed consent to dental emergency treatment (incl. anaesthetic)			
1.6 Dental – routine treatment (incl. anaesthetic)			
1.7 Optician – appointments, glasses			
1.8 Consent to examination/treatment by school doctor			
1.9 Administration of prescribed/over the counter medications			
1.10 Permission for school to administer prescribed/over the counter medications			
1.11 Referral/consent for YP to access another service, eg CAMHS			

1 More than one than one person could have authority to give a particular consent/agreement or undertake a particular task, eg both the parent and foster carer may be attending parents' evenings. If this is the case, the individuals' respective roles should be clarified in the 'Notes' column.

2. Education

Consent/agreement/task	**Who has authority to give consent/agreement or undertake the task**	**Notes** (inc. notifications, prior consultation /recording requirement/conditions)	**Date**
2.1 Signed consent for school day trips			
2.2 Signed consents for school trips of up to four days			
2.3 Signed consents for school trips of over four days			
2.4 School trips abroad			
2.5 Using computers at school			
2.6 School photos			
2.7 Attendance at parents' evenings			
2.8 Attendance at PEP meetings			
2.9 Attendance at unplanned meetings, re incidents or immediate issues			
2.10 Registering at a school			
2.11 Changing a school			
2.12 Referral/consent for YP to access another service (please specify the service)			
2.13 Personal health and social education			

3. Personal, leisure and home life

Consent/agreement/task	**Who has authority to give consent/agreement or undertake the task**	**Notes** (inc. notifications, prior consultation /recording requirement/conditions)	**Date**
3.1 Passport application		*Can only be applied for by someone holding PR*	
3.2 Overnight with friends ('sleepovers')			
3.3 Holidays within the British Isles			
3.4 Holidays outside British Isles			
3.5 Sports/social clubs			
3.6 More hazardous activities, eg horse-riding, skiing, rock climbing			
3.7 Haircuts/colouring			
3.8 Body piercing		*In English law, it is illegal for under 16s to have their genitals pierced. It is also illegal for females under 16 to have their breasts pierced, although this does not apply to males under 16*	
3.9 Tattoos		*It is illegal to tattoo anyone under the age of 18*	
3.10 Mobile phone			
3.11 Part-time employment			
3.12 Accessing social networking sites, eg Facebook, Twitter, MSN			
3.13 Photos or media activity			

4. Faith and religious observance

Consent/agreement/task	**Who has authority to give consent/agreement or undertake the task**	**Notes** (inc. notifications, prior consultation /recording requirement/conditions)	**Date**
4.1 New or changes in faith, church or religious observance			
4.2 Attendance at a place of worship			

5. Identity and names

Consent/agreement/task	**Who has authority to give consent/agreement or undertake the task**	**Notes** (inc. notifications, prior consultation /recording requirement/conditions)	**Date**
5.1 Life history work			
5.2 New or changes in 'nicknames', order of first names, or preferred names			

6. Contact

Consent/agreement/task	**Who has authority to give consent/agreement or undertake the task**	**Notes** (inc. notifications, prior consultation /recording requirement/conditions)	
6.1 Transport			
6.2 Arranging			
6.3 Facilitation			
6.4 Formal supervision			

7. Other areas or categories

Consent/agreement/task	**Who has authority to give consent/agreement or undertake the task**	**Notes** (inc. notifications, prior consultation /recording requirement/conditions)	**Date**

8. Additional notes or questions

Young Person's Evidence & Outcomes Sheet (Guidance Notes)

Be Healthy: *Physical Health* (Food issues & attitudes, physical activities, sickness complaints, ailments.) *Medical appointments* (Dr's, Dentist, Opticians, CAMHS, dates and outcomes, prescribed and non-prescribed medication given.) *Emotional health* (concerns re mental health, distresses, traumas, issues identified.) *Sexual health* (attitudes to sex, awareness of sex, unprotected sex, contraception, safer sex issues, issues raised, concerns.) *Healthy lifestyle* (smoking, drinking, attitudes, drugs, information given.)	**Stay Safe**: *Accidents,* (where, how, action taken.) *Absconding* (dates, times, police incident, people informed, place found, & with who.) *Understanding of personal safety* (risks, road safety, violence, sexual exploitation, neglect of self, maltreatment, friends, family, places of concern.) *Behaviour* (self harming, bullying, discrimination displayed and experienced.) Action Taken. *Antisocial Behaviour* (criminal activity, court appearances, arrests, YOT appointments, curfews, bail conditions, dates, times, incident numbers and appropriate adult feedback.) *Stability (*legal issues, planning issues, placement issues, funding)
Enjoy & Achieve: *education* (preparation for school, attitude to school, attendance, exclusions, achievements, homework issues, detentions, PEP, extra activities to support school, behaviour at school, enjoyment, school reports, parents evening) *Leisure activities* (clubs belong to, activities with peers, activities with the family, attitudes, achievements, concerns.) *Hobbies & interests* (activities to support these.) *Social awareness (*develop positive social skills, develop an understanding of impact upon others, learn new skills). Religious identity (attendance at place of worship, dietary needs, worship within the home) Cultural Identity (dietary needs, language, community links)	**Make a Positive Contribution**: *positive behaviour* (helpful behaviours, changes in attitude, new skills, sanctions imposed, and response to boundaries.) *Relationships* (with peers, friends, family, foster family, extended family, issues, concerns, positives, role models.) *Self esteem* (issues, praise, reward, incentives, opportunities to build self esteem, acceptance of behaviours positive and negative, life changes, decision making.) *Living in the family* (respect for others, participation of household activities, following the household rules.) *Awareness and understanding of community developments and environment* (understand how criminal behaviour or unsociable behaviour impacts on community, i.e. supporting local groups or school in fund raising, promoting positive behaviour and being a good role model). Contact with whom, dates times, places, supervisor and issues. Behaviour prior and after contact. Positives.
Achieve economic well-being: *pocket money* (use of it, how it is earned, and how much it is). *Savings* (bank account, what savings are used for, who contributes to it.) *Budgeting (*for independence skills, for the week with activity money, clothing allowance, lunch money, bus fare. If it is being used productively by the young person). *Earning* (pocket money, paper round, employment, extra jobs around the house). *Looking after belongings* (ability to do this.) Preparation for independence (skills, ,planning for training, further education or employment, progress with pathway plan, attitude and achievements)	

If you require any further guidance on how to complete the Evidence & Diary Sheets, please do not hesitate to contact your Supervising Social Worker.

Foster Carer: …… Month…… Year……

Young Person: …… Age……

Be Healthy	**Stay Safe**
Enjoy & Achieve	**Make a Positive Contribution**
Achieve Economic Well-being	**Action Plan/Tasks:** **Target Date: _____** *To be completed with Supervising Social worker and carer.*
Signatures:- **Foster Carer……** **Young Person……..…** **Date…….**	**Young Persons comments:-**

Wiltshire Council
Department for Children and Education

Daily diary sheets are expected for:

- Bail & Remand Carers
- Carers at all levels with short-term placements
- Respite (per episode)

Weekly diary sheets are expected for long-term, stable placements unless daily diary sheets are specifically requested.

A Foster Carers Incident Report Form must be completed on the day of any notifiable incident (see Incident Report Form for details of events that must be notified).

Name of child:

Name of Carer(s):

Date of recording:

Please record any incidents, health issues, injuries, specific areas of concern or achievements (including educational) of foster child. Please also record family contacts, and significant reactions, if any, to contacts.

Any of the above should be recorded on the day they occur.

Recording should be of factual information. If you record personal opinion, please state that it is an opinion and not fact. Please use both sides of the form.

Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

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Signed ……

Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

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Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

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Signed ……

Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

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Any of the above should be recorded on the day they occur.

Recording should be of factual information. If you record personal opinion, please state that it is an opinion and not fact. Please use both sides of the form.

Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

Date:

Signed ……

Wiltshire Council
Department for Children & Education

To be completed by the child's foster carers

Carers' Names (1): ……

(2): ……

Carers' Address:

……

Child's Name:…….. DoB: ……

Child's Social Worker:……..

Carers Fostering Social Worker:……

Date Placement Started: ……

Date Placement Ended: ……

Preparation

Were you adequately prepared for the placement by:

(a) Your Fostering Social Worker Yes ☐ No ☐

(b) The child's social worker Yes ☐ No ☐

(c) The Fostering Duty Officer Yes ☐ No ☐

Please comment:

……
……
……

Did you receive adequate information about the child, including:

Family Background Yes ☐ No ☐
Care Plan Yes ☐ No ☐
Reasons for Accommodation Yes ☐ No ☐
Initial Assessment Yes ☐ No ☐
Placement Request Form Yes ☐ No ☐
Core Assessment Yes ☐ No ☐
Statutory Review Form Yes ☐ No ☐
Behaviour Checklist Yes ☐ No ☐
Background Health Information Yes ☐ No ☐

Please comment:

……
……
……

When was the placement Agreement Meeting? ……

Were the aims of the Placement achieved? Yes ☐ No ☐

Support During the Placement

How often did the child's social worker visit? ……

Did the social worker see the child alone? Yes ☐ No ☐

Please comment:

……
……
……

Did the social worker occasionally see the child's bedroom?
Yes ☐ No ☐

Please comment:

……
……
……

Did the social worker give you updated information about the child throughout the placement? Yes ☐ No ☐

Please comment:

……
……
……

How often did your Fostering Social Worker visit during the placement?

Did they spend time talking to your own children during the placement?
Yes ☐ No ☐

Please comment:

……
……
……

If you needed to contact the Emergency Duty Service during the placement were you satisfied with the response? Yes ☐ No ☐

Please comment:

……
……
……

General/Practical Matters

Did you receive any additional financial support for the child during the placement? Yes ☐ No ☐

Please comment:

……
……
……

Were you consulted about and involved in the child's contact arrangements, or changes to the arrangement? Yes ☐ No ☐

Please comment:

……
……
……

Were the practical arrangements for contact satisfactory? Yes ☐ No ☐

Please comment:

……
……
……

How did you support the child's Personal Education Plan?

……
……
……

How did you support the child's Health Care Plan?

……
……
……

What were the most enjoyable aspects of the placement?

……
……
……

What were the most difficult aspects of the placement?

……
……
……

Are there any other comments you wish to make about the placement?

……
……
……

Signed:…… Carer 1

Signed:…… Carer 2

Date:……..…

N.B. At the end of the placement please return to the Department all papers and information relating to the child.

Foster Carers Incident Report Form

Name of Young Person:	
Young Persons Date of Birth:	
Carers Name:	
Date of incident/event	

Reg 36 (1) (Schedule 7) (Please tick as appropriate)	
Missing ☐	Allegations of serious crime ☐
Police being called to carers home ☐	Involvement in prostitution ☐
Serious illness/accident ☐	Serious incident involving Police ☐
Child protection issue ☐	Infectious disease ☐
Brief outline of event/action taken:	

People Notified:	(Please tick as appropriate)
Childs Social Worker ☐	Fostering Social Worker ☐
Police ☐	Child's Parents ☐
Out of hours (OOH's Fostering Service advice)☐ Emergency Duty Service (EDS)☐	Other (specify)☐

Signed:	
Carer:	
Date:	

In addition to contacting the child's social worker please contact your fostering worker, or the fostering support and supervision duty worker, without delay if a child in your care is involved in an incident or event outlined above.

This can be done by telephone within 24 hours/next working day and followed up by completing the incident report form.

Please pass the completed form to your supervising social worker as soon as possible.

More serious events should trigger an immediate telephone call to your supervising worker, the fostering duty worker if they are unavailable or EDS/fostering OOH support line if the incident happens outside normal office hours.

E mails or leaving a message on voice mail must not be relied on as the sole method of communication.

Foster Carers Incident Report Form

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Young Persons Date of Birth:	
Carers Name:	
Date of incident/event	

Reg 36 (1) (Schedule 7) (Please tick as appropriate)	
Missing ☐	Allegations of serious crime ☐
Police being called to carers home ☐	Involvement in prostitution ☐
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People Notified:	(Please tick as appropriate)
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Police ☐	Child's Parents ☐
Out of hours (OOH's Fostering Service advice)☐ Emergency Duty Service (EDS)☐	Other (specify)☐

Signed:	
Carer:	
Date:	

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Young Persons
Education Record

School Details	
Name of School:	
Headteacher:	
Address:	
Contact Number:	
School Contacts	
Designated Teacher	
Name:	
Contact Number:	
Tutor	
Tutor Group:	
Tutors Name:	
Contact Number:	
Virtual School Officer	
Name:	
Contact Number:	

PEP's		
Dates of PEP:		
1.	2.	3.
4.	5.	6.
7.	8.	9.

Carers contact with school (e.g. open days, fete, parents evening)	
Date	**Event**

Record of young person's Achievements		
Date	Type of Achievement	Comments

Attendance / Absence (To include holidays, exclusions and sickness)		
Date – From	To	Reason

Wiltshire Council Fostering Service
HEALTH DIARY

If medication administered (prescribed or over the counter) record details on medication recording form

Name of child / young person	
Brief Outline of event /action taken	

DATE:	ROUNTINE HEALTH APPOINTMENT including dentist and optician/**ILLNESS/**ACCIDENT/INJURY/TREATMENT INCLUDING FIRST AID: **If serious illness/accident also complete incident report form (section)
DATE:	ROUNTINE HEALTH APPOINTMENT including dentist and optician /**ILLNESS/**ACCIDENT/INJURY/TREATMENT INCLUDING FIRST AID: **If serious illness/accident also complete incident report form (section)
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Medical Information and Medication Recording Form

Child's Name:	**GP's Name:**	**Health Need and support task required:**
Date of Birth:	**GP's Tel:**	**Equipment Required:**
For Parent /Social Worker to complete:		
Parent(s):	**Parent(s) Tel:**	**Training Required to meet health need**

I the parent / Social Worker (insert your full name) …… am willing for the carer …….. (insert carers full name) to carry out health support/tasks stated above. Providing s/he has had the appropriate training from a suitably qualified person (e.g. Community Nurse, School Nurse, GP, etc).

For Carer/Respite Carer to complete, Please give details of training completed :	
Training Type and Date	**Name of Trainer and position :**
Authorised and recorded by Children's Service:	**Date**

I ..... (insert carers full name) am willing to undertake the tasks stated above and have received adequate training and supervision

Carer Signed :	**Date**
Fostering Social Worker Signed :	**Date**

Medical Information and Medication Recording Form

Medication received and returned

Medication received				Medication returned			
Date	**Medicine**	**Qty**	**Sign**	**Date**	**Medicine**	**Qty**	**Sign**

- All medication must be in the original bottle or box, with the pharmacist's label attached.
- The label must include the child's name, medication name, strength, dose and time of administration. It is not permitted to administer medication from a container that says, 'as directed.
- Labelling must correspond to the written instructions from the GP, consultant or parent.
- Any discrepancies should be brought to the attention of the parent/carer/social worker.
- It is not permitted to administer prescribed medication to anyone for whom it was not prescribed.
- Medication must be stored safely within the foster home

Medical Information and Medication Recording Form

Record of ALL medication given to the child or young person – where the young person wishes to, and can do so safely, they should be able to keep and take their own medication – this should agreed as part of delegated authority and must still be recorded

Date and Time	Medicine	Dose	Method of Administration	Signed Given	Refusal of Medication/ Side Effects/Observations