Child's photo

SACRED HEART PRIMARY SCHOOL THORNLIE CHILD CARE SERVICES
HEALTHCARE & RISK MINIMISATION PLAN

Child's Name:		**Date of birth:**
Medical Condition:		**Gender:**
CONTACT INFORMATION		
Emergency Contacts:	**Parent/carer information (1)**	**Parent/carer information (2)**
	Name:	**Name:**
	Relationship:	**Relationship:**
	Home phone:	**Home phone:**
	Work phone:	**Work phone:**
	Mobile:	**Mobile:**
Medical practitioner:	**Name:**	**Phone:**
Specialist:	**Name:**	**Phone:**
Other emergency contacts:(if parent/carer not available):	**Emergency Contact Information (1)**	**Emergency Contact Information (2)**
	Name:	**Name:**
	Relationship:	**Relationship:**
	Home phone:	**Home phone:**
	Work phone:	**Work phone:**
	Mobile:	**Mobile:**

MEDICAL CONDITION INFORMATION	
Details of Medical condition:	
Signs and symptoms of child's condition:	
Triggers or things that make your child's condition worse:	
Routine healthcare requirements:	
What to do in an emergency- list details below or tick ☐ and attach your EMERGENCY ACTION PLAN:	

MEDICATIONS	
Medication/s to be taken while in care	**Emergency Medications**
Name/ Type of Medication:	**Name/ Type of Medication:**
Dose and Method of Administration:	**Dose and Method of Administration:**
When it is to be taken (time of day):	**Describe the signs and symptoms that indicate an emergency for your child:**
Are there any side effects of this medication (If yes, please list below):	**Are there any side effects of this medication (If yes, please list below):**
	Is there any follow up care required?

MANAGEMENT CONSIDERATION FOR THE SERVICE (PLEASE INCLUDE INFORMATION EDUCATORS AND STAFF WILL NEED TO KNOW TO CARE FOR YOUR CHILD)	
Impact on capacity to attend and participate in routine experiences:	
Limitations on physical activity:	
Need for rest or respite:	
Need for additional emotional support:	
Behaviour management plan:	
Considerations necessary for excursions:	
Other:	
PARENT AGREEMENT: I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education, including emergency services. I agree to my child's healthcare plan and action plan (including photo) being displayed in the centre in a prominent place to alert all staff, volunteers and students. I understand that I must notify the service of any changes in writing. I acknowledge I have received a copy of the relevant medical conditions and medications policies.	
Name of parent/carer:	**Date:**
Signature of parent/carer:	
Name of Nominated supervisor/Enrolling staff member:	**Date:**
Signature of Nominated supervisor/Enrolling staff member:	
Healthcare plan review date:	**Action Plan review date:**

Child's Name:		Date of Birth:
Risk	**Strategy**	**Who is Responsible?**

Communication	Date Received	Parent Signature	Educator Signature	Information communicated to Educators

MEDICATION CHECK		
Expiry date of child's medication provided		
Quarterly checks for date of expiry on medication	**Date**	**Signature**
	Date	**Signature**
	Date	**Signature**
	Date	**Signature**

I am familiar with: **(Educators, please write name and initial below)**	**Name**	**Name**	**Name**	**Name**	**Name**	**Name**	**Name**	**Name**	**Name**	**Name**
The child										
The child's medical condition										
The child's healthcare and action plan										
The location of the child's healthcare and action plan										
The location of the child's medication										
The child's risk minimisation plan										

I have performed the following:	**Nominated/ Certified Supervisor Signature**	**Date**
Informed families of the child's known allergens		
informed families of relevant risk minimisation strategies		
Communicated the Child's healthcare plan and risk minimisation plan to Educators		

Healthcare Plan Review Date	**Communicated to Educators**	**Staff Name**	**Signature**