**To be completed by the parent / guardian in conjunction with the nominated supervisor**

Regulation 90 of the Education and Care Services National Regulations requires a risk-minimisation plan for the management of medical conditions for children in care. The term medical conditions include, but is not limited to asthma, diabetes or a diagnosis that a child is at risk of anaphylaxis. The risk management plan should be developed through consultation between the parents/guardians of the child and the child care service.

Child’s full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_

Details of medical condition / health requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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A medical management plan is required for children who suffer from asthma, diabetes or have been diagnosed at risk of anaphylaxis. A medical management plan may also be required for other health conditions.

Has a medical management plan been submitted for this condition? Y  N 

**Predominant known triggers for the medical condition and potential reaction/s**

 **Trigger Reaction**

# Frequency of symptoms / reactions

How often does your child display symptoms of suffer from reactions of the medical condition?

* Infrequent (5 or less per year) Occasionally (6 or more per year)
* MonthlyWeekly
* DailyWhen exercising

How do you as a parent / guardian recognise the symptoms / reactions?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child always able to recognise the symptoms / reactions?Y  N 

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medication

Does your child require medication to treat the medical condition? Y  N 

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your child require medication whilst in care? Y  N 

If yes, a Medication Authorisation Form **must** be completed

Is your child permitted to self-medicate? Y  N 

The circumstances under which the medication required is to be administered to your child whilst in care:

* As detailed in the management plan As per medication label / Doctor instructions
* Other (supply details)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**How can we minimise the risks relating to your child's health care needs / medical condition and what strategies can we implement to avoid triggers?**

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| --- | --- | --- |
| **Risk**  | **Strategy**  | **Who is Responsible**  |
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| Communication Plan Regulation 90 |

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Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date**  | **Issue / Concern / Request / Information**  | **Action Required**  | **Actioned By**  | **Communicated to Staff**  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| **Parent / Guardian Contact (1)**  | **Parent / Guardian Contact (2)** |
| Name:  | Name:  |
| Relationship to child: | Relationship to child: |
| Home phone: | Home phone: |
| Work phone: | Work phone: |
| Mobile phone: | Mobile phone: |

|  |  |
| --- | --- |
| **Emergency Contact is not contactable**  | **Medical Practitioner contact** |
| Name:  | Name:  |
| Relationship to child: | Phone: |
| Home phone: |  |
| Work phone: |  |
| Mobile phone: |  |

**This Medical Condition Risk Minimisation and Communication Plan has been developed with my knowledge and input and will be reviewed at the commencement of terms 1 & 3 of school each year or as required.**

**Next review date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_**

**Parent / Guardian signature:**

 **Name: Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_**

**Nominated Supervisor signature:**

 **Name: Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_**