CAMPBELLTOWN CITY COUNCIL

Education and Care Services

Medical Condition Plan

Privacy Statement

The information requested by Council on this form may constitute personal information under the Privacy and Personal Information Protection Act 1998. Council is allowed to collect the information from you to consider this matter. Supplying this information is voluntary. However if you cannot or do not wish to provide the information, we may not be able to consider the matter. If you need further details, please contact the Privacy Officer, Campbelltown City Council, cnr Queen and Broughton Streets, Campbelltown. Please note that information provided may be shared with Department of Education (DEC), the Police, other relevant agencies and educators in accordance with applicable legislation.

This form must be accompanied by a Medical Management Plan from your child's doctor.

Child's name _____ Service _____

Date of birth _____ Age _____

Child's address _____

Medical condition _____

Child's Photo

Possible signs and symptoms

Usual signs and symptoms	Worsening signs and symptoms

If the specific health issue/reaction occurs refer to the doctor's Medical Management Plan for treatment

Authorisation for Management Plan to be followed

I _____ being the parent/guardian of _____

authorise a first aid qualified Educator to administer the nominated medication/injection to my child, if necessary as noted on the Management Plan from the doctor.

I give / do not give **(please circle)** permission for my child _____ to self-administer their medication.

Medication provided by me, will be kept at the service at all times (or with the child at all times – OSHC only).

Parent/guardian signature _____ Date _____

Risk Minimisation Plan

This plan has been developed in consultation with the child's parents/guardians and is valid for 12 months. The plan is implemented to help to ensure that the risks relating to the child's specific health care need, allergy or relevant medical condition are assessed and minimised.

Known allergens	Potential sources/times for exposure	Potential reactions	Likelihood/impact (use matrix)	Strategies to minimise risk	Likelihood/impact after strategies are implemented (use matrix)	Who is responsible

☐ I have read and understood the service's procedures in relation to the safe handling preparation, consumption and service of food (Nutrition Procedure).

Are there any additional practices regarding the safe handling, preparation, consumption and service of food required to minimise the risks relating to your child's medical condition? ☐ Yes ☐ No

If Yes, please specify: _____

☐ I understand it is my responsibility to provide my child's medication prescribed by my doctor in relation to the medical condition.

☐ I understand that my child is not permitted to attend the service without their _____
(name of prescribed medication)

Parent/guardian's name _____ Parent/guardian's signature _____ Date _____

☐ The child, the child's photo, the child's medical condition and details of the location of the child's Medical Condition Plan have been added to the 'Information for Service/Staff' form which is on display (LDC/OSHC only).

☐ A current copy of the child's emergency contact information is attached to this form.

Supervisor's name _____ Supervisor's signature _____ Date _____

Risk Benefit Analysis Matrix		Consequences				
		Insignificant	Minor	Moderate	Major	Extreme
Likelihood	Rare	Low	Low	Low	Moderate	High
	Unlikely	Low	Low	Moderate	High	High
	Possible	Low	Moderate	High	High	Extreme
	Likely	Moderate	Moderate	High	Extreme	Extreme
	Almost certain	Moderate	High	High	Extreme	Extreme

The following people undersigned have been involved in the preparation of and have read, understood and agreed that this document is best practice for the risk minimisation of the 'at risk' child identified in this plan. The parents/guardians agree to notify the service/FDC educator of any changes in writing as soon as possible and a new Medical Condition Plan will be completed.

FDC educator's/Supervisor's name _____

FDC educator's/Supervisor's signature _____ Date _____

Parent/guardian's name _____

Parent/guardian's signature _____ Date _____

Communication Plan			
The following staff/educators/volunteers acknowledge that they: • have read and understood the Medical Conditions procedure • are informed about the child's medical condition outlined in this Medical Condition Plan • have read, understood and know the location of the child's Medical Condition Plan • know how to use the child's medications and where they are stored (only relevant if holding a current first aid certificate)			
Name	**Position**	**Signature**	**Date**
Note: Supervisors must ensure all educators/staff/volunteers are advised of any changes to a child's medical condition by completing a new Medical Management Plan.			

Beginning of Each Term								
A meeting between the parent/s and educator must be scheduled to ensure that this Medical Condition Plan and medication provided are still applicable to the child's condition. Medication must be correctly labelled with name of medication, child's name, dosage, circumstances for administration of it to the child and within "use by" dates. Each party is required to sign the plan in the table below to confirm the above information is still current. If a parent or guardian has any changes to the Medical Condition Plan it must be communicated in writing (preferably via email) to the Nominated Supervisor/FDC Educator. Once written confirmation of changes is received, the Nominated Supervisor/FDC Educator must ensure that a revised Medical Condition Plan is developed and the changes are communicated to all educators, staff and volunteers/Educator Assistants. General information such as exposures, reactions, follow up appointments, etc. can be documented below in the comment/progress notes section.								
Term Date	**Term 1**		**Term 2**		**Term 3**		**Term 4**	
Parent signature								
Supervisor signature								
Medication still valid	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Medication stored								
Emergency contact information is current and attached to this form	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Date reviewed								

Date	Comments/Progress notes Note: A new Medical Management Plan must be completed if there are any changes required.	Parent/Guardian signature	Educator signature