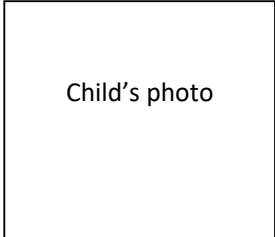




Liwara Catholic Outside Hours Care

HEALTHCARE PLAN AND RISK MINIMISATION PLAN



Child's Name:		
Date of birth:		Gender:
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)		
Heath Care Action Plan provided by parent/carer (please circle): YES / NO		
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 health requirements:		
Medication to be administered while in care:		
What to do in an emergency- list details below and attach your EMERGENCY ACTION PLAN:		
Signature of parent/carer:		Date:
Food coordinator:		Date:
Lead Educator:		Date:
Nominated supervisor/Enrolling staff member:		Date:



Educators signature: _____ Date _____

