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| --- | --- | --- | --- | --- |
| 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 practictioner | 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: |

**A close up of a sign

Description automatically generated Liwara Catholic Outsdie Hours Care**

Child’s photo

**HEALTHCARE PLAN**

**AND**

**RISK MINIMISATION PLAN**

**Date Written: Review date:**

**Risk minimisation plan - Strategies to Avoid Health Triggers**

(to be developed in partnership with childs families and educators)

|  |  |  |
| --- | --- | --- |
| Child’s name: | | |
| Risk | Strategy | Who is Responsible? |
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I/we agree to these arrangements, including the display of our child’s picture, first name, medication held and location, and brief description of allergy/condition on a poster in all children’s rooms and prominent places to alert all staff, volunteers and students.

Parents signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educators signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Conditions Risk Minimisation**

**Communication Plan**

**Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Asthma, allergy or medical condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- |
| ***Communication*** | ***Date*** | ***Educator Signature*** | ***Parent Signature*** |
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