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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: |

** 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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