Medical Management Plan

Child's Name: ..... **Child's Date of Birth:** ...../...../.....
Plan Implementation Date: ...../...../..... **Next Review Date:** ...../...../.....

This plan must be recompleted at least annually, and updated with any changes as required.

Insert child's photo (in colour).

Details of Child's Condition (Condition, symptoms and triggers)

- .....
- .....
- .....
- .....
- .....

Risk Minimisation Plan (Steps to be taken to minimise risk or exposure, including medication to be administered)

- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

Location of Medication:.....

Action Plan (Step by step actions to be taken)

- .....
- .....
- .....
- .....

DOCUMENT NUMBER & TITLE	NQS2 Medical Management Plan APPENDIX				
CONTENT OWNER	Kylie Warren-Wright, National Health and Safety Manager – Governance and Risk		**DOCUMENT AUTHOR**	Kylie Warren-Wright, National Health and Safety Manager – Governance and Risk	
DATE PUBLISHED	1/1/2016	**DOCUMENT VERSION**	V11.0	**REVISION DUE DATE**	31/12/2017
RECORD MANAGEMENT SCHEDULE	Child Enrolment - C+3yrs				
Ensure you are using the latest version of this policy. You can find it at http://policies.goodstart.org.au/PoliciesandProcedures/NQS2%20Medical%20Management%20Plan%20APPENDIX.docx					
Warning – uncontrolled when printed. This document is current at the time of printing and may be subject to change without notice.					

Emergency contact details are located on the reverse of this form.

Parent/Guardian

Name: .....

Mobile: .....

H: ( ) ..... W: ( )..... Signature:..... Date:...../...../.....

Parent/Guardian

Name: .....

Mobile: .....

H: ( ) ..... W: ( ) ..... Signature:..... Date:...../...../.....

This plan is to be displayed in an area accessible by staff who are responsible for your child's education and care. Your plan will be displayed in the…… To comply with the Education and Care Services National Regulations your consent is required. This information will not be used for any purpose other than to ensure the wellbeing of your child.

Name: ……Signature:..... Date:...../...../.....

Medical Practitioner

Name: .....

B: ( )..... W: ( )..... Signature:.....Date:...../...../.....

Documentation provided by Medical Practitioner (attached):

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Please note: A separate medical management plan is to be provided by a Medical Practitioner for Diabetes and Epilepsy which must include a detailed action plan for the management and treatment of these conditions.

Communication Plan	Date
• Relevant staff and volunteers have been informed about Goodstart's Medical Conditions Requirement.	
• Relevant staff and volunteers have been informed about this medical management plan and risk minimisation plan and know where to locate this plan in the case of an emergency, refer to Medical Management Plan Informed Consent.	
• Goodstart's Medical Conditions Requirement has been provided to the family.	