

Medical information

for education, childcare and community support services

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a child/student/client who requires individual health and personal care support. Some condition-specific forms are also available.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Description of the condition

Observable signs and symptoms _____

Frequency and severity _____

Triggers (if applicable) _____

Possible impact on activities (eg physical activity, camps, excursions, kitchen, laboratory or workshop activities, interrupted attendance)

First Aid

If a child/student/client becomes ill or is injured, supervising staff will administer first aid and call an ambulance if necessary.

If you anticipate this child/student/client will require anything other than a standard first aid response, please provide detailed written recommendations so special arrangements can be negotiated.

Additional information attached to this care plan

- Medication authority (if supervision of medication is recommended while in education or child/care)
- Individual first aid plan (if different to standard first aid—see model over page)
- General information about this person's condition
- Other (please specify) _____

This plan has been developed for the following services/settings:

- | | |
|--|--|
| <input type="checkbox"/> School/education | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care | <input type="checkbox"/> Work |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (please specify) |

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

Telephone _____

Signature _____ Date _____

**I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.**

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

Individual first aid plan

for education, child/care and community support services

CONFIDENTIAL

To be completed by the HEALTH PROFESSIONAL and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a child/student/client who requires individual first aid assistance.

Standard first aid plans (for a range of conditions) can be found on <http://www.decd.sa.gov.au/speced2/pages/health/chessPathways/>
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

The child/student/client has a medical condition described as _____

And will require the following first aid response when these symptoms/reactions are observed.

Observable sign/reaction	First aid response
<input type="text"/> <input type="text"/> ▽	<input type="text"/> <input type="text"/> ▽
<input type="text"/> <input type="text"/> ▽	<input type="text"/> <input type="text"/> ▽
<input type="text"/> <input type="text"/> ▽	<input type="text"/> <input type="text"/> ▽
<input type="text"/> <input type="text"/> ▽	<input type="text"/> <input type="text"/> ▽

This plan has been developed for the following services/settings: *

- | | |
|--|--|
| <input type="checkbox"/> School/education | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care | <input type="checkbox"/> Work |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (please specify) _____ |

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

Telephone _____

Signature _____ Date _____

**I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.**

Parent/guardian or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)