Medical Management and Communication Plan

* The Medical Management Plan is to be completed by the child’s family
* The child’s family should inform Clarence Children Services or their OSHC Service immediately if there are any changes to this plan.

Would you like a meeting with Clarence Children’s Services and the OSHC service staff to discuss your child’s medical condition? Yes No

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| Child’s Name: ………………………………………………………………………………………………….  Date of Birth: ……………………………………………..  OSHC Service: ………………………………………………………………………………………………….  Emergency contacts/ next of kin:   1. Name: …………………………………………………………… Relationship: …………………..   Contact numbers: …………………………………………………………………………………………..   1. Name: …………………………………………………………… Relationship: …………………..   Contact numbers: …………………………………………………………………………………………..  Doctor: ………………………………………………………………………………………………………………………  Contact number: ……………………………………………………………………………………………………….. |

Please provide detail of the medical condition (eg Asthma, Diabetes, ASD, Anaphylaxis) ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  
Symptoms, triggers/behaviours and consequences of medical conditions:  
………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  
What can be done to minimise the risk? (Allergens, Environments, Situations )  
………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  
Educator training is required to support my child’s needs? Yes No  
Does the child self-medicate? Yes No  
Does your child take any preventative medication? Yes No  
Name of medicate, type (tablet, liquid, puffer etc), dosage and frequency:  
1. ……………………………………………………………………………………………………………………………………  
2. ……………………………………………………………………………………………………………………………………  
3. ……………………………………………………………………………………………………………………………………  
4. ……………………………………………………………………………………………………………………………………  
 *(All Medication administered to be recorded on Authorisation and Administration of Medication form)*

**Emergency Procedure**Please clearly describe the steps your OSHC Service should take in case of an emergency.  
……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….  
Is there any further information we should know in relation to your child’s medical condition and how your child can be supported?  
………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  
   
**Communication Plan  
Declaration of parent / guardian:**

* I will ensure my OSHC Service is fully aware of the medical requirements when caring for my child.
* I agree to my child receiving the treatment described in this document.
* I authorise my child’s OSHC service to assist my child with taking medication should he / she require help.
* I will renew this Medical Management Plan annually (or prior to expiry) if there are any changes to my child’s medication and forward to my OSHC Service or Clarence Children’s Services office.
* I will advise my OSHC Service on the day of symptoms requiring medication in the past 48 hours and the cause of the symptoms if known.
* I will ensure the educator has adequate supplies of my child’s medication.

Name of parent / guardian: ……………………………………………………………………………………

Signature of parent / guardian: …………………………………… Date: ………………………….

**The OSHC Service agrees to:**

* Follow the action plan detailed above.
* Will advise the parents if the child’s medication needs to be replenished.
* Ensure that the required medication is available at all times.
* Where relevant, inform all current families of having a child in care with a medical condition and will endeavour to minimise the risks identified in this plan.
* Will provide a copy of this plan to the Clarence Children’s Services office whenever it is updated.
* will follow the emergency action plan if / when required

**If the child’s condition suddenly deteriorates of if at any time you are concerned, call an ambulance immediately – Dial 000** Original - Office Parent Copy Service Copy