St Andrews Lutheran College OSHC

WHS.019 General Health Management Plan

This form is to be completed by parents in consultation with their child's doctor and returned to the Service prior to commencement. Parents are required to inform the Service of any changes to their child's condition or treatment immediately. It is recommended that this form be revised at six monthly intervals.

Child's full name | **Date of birth** | **Male** ☐ **Female** ☐

Medical condition covered by this Management Plan

Medication required to be administered in the event the Management Plan is implemented

Name of medication	Dosage	Method

Symtoms, triggers and signs that my child's medical condition requires treatment

Symptoms	Factors that may trigger symptoms	⚠ Signs that indicate that the emergency plan should be implemented.

Please add the details of people (and their contact details) below that are authorised to consent to medical treatment and to collect your child should the Service decide they are unfit to remain in care.
Each person on this list will be telephoned until contact is made with one person.

Name		Contact number		Relationship	
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In the event of a health emergency, I agree to my child receiving the treatment described above.
I authorise employees of the Service to administer or assist my child with taking medication should he/she require assistance.
I will notify you in writing if there are any changes to these instructions.

Parent/Guardian name		Date plan completed	
Parent/Guardian signature		Date to be reviewed	

Child's full name

Date of birth

Male ☐

Female ☐

Place photo of child here

Medical condition covered by this Management Plan

In the event of a health and/or medical emergency, relating to the medical condition covered by this Management Plan, please follow the instructions developed in consultation with our Doctor as outlined below

Medical Practitioner name

Contact number

Medical Practitioner signature