

# 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:

School/education

Child/care

Respite/accommodation

Transport

Outings/camps/holidays/aquatics

Work

Home

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)