



## Medical Condition Risk Minimisation Plan

### To be completed by the parent / guardian in conjunction with the nominated supervisor

Regulation 90 of the Education and Care Services National Regulations requires a risk-minimisation plan for the management of medical conditions for children in care. The term medical conditions includes, but is not limited to asthma, diabetes or a diagnosis that a child is at risk of anaphylaxis. The risk management plan should be developed through consultation between the parents/guardians of the child and the child care service.

Child's full name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_

Details of medical condition / health requirements: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

A medical management plan is required for children who suffer from asthma, diabetes or have been diagnosed at risk of anaphylaxis. A medical management plan may also be required for other health conditions.

Has a medical management plan been submitted for this condition? Y ☐ N ☐

### Predominant known triggers for the medical condition and potential reaction/s

#### Trigger

#### Reaction

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Frequency of symptoms / reactions



## Medical Condition Risk Minimisation Plan

How often does your child display symptoms of suffer from reactions of the medical condition?

- |  |  |
|--|--|
| <input type="checkbox"/> Infrequent (5 or less per year) | <input type="checkbox"/> Occasionally (6 or more per year) |
| <input type="checkbox"/> Monthly                         | <input type="checkbox"/> Weekly                            |
| <input type="checkbox"/> Daily                           | <input type="checkbox"/> When exercising                   |

How do you as a parent / guardian recognise the symptoms / reactions?

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Is your child always able to recognise the symptoms / reactions? Y ☐ N ☐

Details: 

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### Medication

Does your child require medication to treat the medical condition? Y ☐ N ☐

Details: 

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Will your child require medication whilst in care? Y ☐ N ☐

If yes, a Medication Authorisation Form **must** be completed

Is your child permitted to self-medicate? Y ☐ N ☐

The circumstances under which the medication required is to be administered to your child whilst in care:

- |   |  |
|---|--|
| <input type="checkbox"/> As detailed in the management plan | <input type="checkbox"/> As per medication label / Doctor instructions |
| <input type="checkbox"/> Other (supply details)             |  |

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## Medical Condition Risk Minimisation Plan

How can we minimise the risks relating to your child's health care needs / medical condition and what strategies can we implement to avoid triggers.

Risk	Strategy	Who is Responsible

## Communication Plan

Regulation 90

Name of Child: \_\_\_\_\_



Newton Family Day Care

Date	Issue / Concern / Request / Information	Action Required	Actioned By	Communicated to Staff

**Parent / Guardian Contact (1)**

Name: \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Mobile phone: \_\_\_\_\_

**Parent / Guardian Contact (2)**

Name: \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Mobile phone: \_\_\_\_\_

**Emergency Contact is not contactable**

Name: \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Mobile phone: \_\_\_\_\_

**Medical Practitioner contact**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**This Medical Condition Risk Minimisation and Communication Plan has been developed with my knowledge and input and will be reviewed at the commencement of terms 1 & 3 of school each year or as required.**

Next review date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Parent / Guardian signature:** \_\_\_\_\_**Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_**Nominated Supervisor signature:** \_\_\_\_\_**Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_