Non-specific Health Care Plan

for education and care



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| To be completed by the treating health professional and parent or legal guardian for a child or young person requiring additional care or supervision related to their physical or mental health and wellbeing.  (Note: other proformas are available for more specific health care plans)  This information is confidential and will be available only to relevant staff and emergency medical personnel. | | | |
| Name of child/young person: |  | | |
| DOB: |  | Review date: |  |
| Allergies: |  | | |
| Education or care service: |  | | |  |

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| **DESCRIPTION OF THE CONDITION**  It is not necessary to provide a full medical history. Education and care staff only need to know information relevant to the child or young person’s attendance, learning and wellbeing in education and care settings. |
| Provide details |

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| **IMPLICATIONS FOR EDUCATION AND CARE SETTINGS**  Only include information that is relevant for supervising staff to teach and care for the child or young person (for example): | |
|  | Impact on capacity to attend and participate in routine learning activities |
|  | Limitations on physical activity |
|  | Need for rest and/or privacy |
|  | Need for additional emotional support |
|  | Behaviour management plan |
|  | Considerations for camps, excursions, social outings |
| Provide details | |

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| **DESCRIPTION OF WARNING SIGNS, TRIGGERS, CIRCUMSTANCES AND RECOMMENDED RESPONSE** |
| Provide details |

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| **ADDITIONAL INFORMATION** |
| Provide details |

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| **AUTHORISATION AND AGREEMENT**  *(To be signed after form has been completed)* | | The following settings have been considered in the development of the health care plan and is appropriate for use in the following: | | | | |
|  | Children’s centre, preschool or school | | |  | Childcare, Out of School Hours Care | |
|  | Camps, excursions, special event, transport (incl. aquatics) | | |  | Work experience or other education placement | |
|  | Respite, accommodation | | |  | Work | |
|  | Transport | | |  | Other (specify) | |
| *Treating health professional* | | | | | | |
| Print name & practice/hospital or stamp | | | Professional role | | | |
| Email or signature | | | |
| Telephone | | | Date | | | |
| *Parent or legal guardian; or adult student* | | | | | | |
| * **I understand and agree with the health care plan as indicated above** * **I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).** * **I understand staff may seek additional information and/or advice regarding the medical information contained in the individual first aid plan from the Access Assistant Program (AAP) to inform duty of care.** | | | | | | |
| Name | | | | | | Relationship |
| Email or signature | | | | | | Date |