EIKOH SEMINAR AUSTRALIA PTY LTD

Medical Management Plan and Risk Minimisation

Photo of Child

Child's Name: _____

Date of Birth: _____

Does this child have a medical action plan: _____

Plan date: _____ **Review date**: _____

Child's Room: _____

Child's Medical Condition: _____

Triggers for allergy or medical condition:

_____

_____

_____

_____

First Aid/ Medication Required:

_____

_____

_____

Where is this child's medication stored:

_____

Steps to be taken to minimise triggers for allergy or medical condition (add extra pages as required):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent:

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to educators and emergency medical personnel. I will notify the educators in writing if there are any changes to these instructions. I will ensure that at all times any medication required for my child's medical condition will be on the centre premises, kept in date and if at any time I cannot adhere to this and my child's medication is not at the centre I understand that my child may not be able to attend until I can provide the medication prescribed as outlined in my child's medical action plan.

Name: _____

Signature: _____

Date: _____

Centre Director:

I have completed this form with the child's parents and agree to update any changes received by the parent. I acknowledge that all educators working directly with this child will be shown this document and asked to sign it. This document will be kept in a prominent place and updated as needed while the child remains in our care.

Name: _____

Signature: _____

Date: _____

Educators working with the child are to read this document and sign their name and signature with the date below acknowledging that they have read and understood this document.