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.**
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| Name | Relationship |
| Email or signature  | Date |