MEDICAL MANAGEMENT PLAN

This form is to be completed by the child's medical practitioner and provides a description of the health condition and first aid requirements for a child with specific healthcare needs. This information will assist the Service in developing a Risk Minimisation Plan, which outlines how educators and staff will support the child's medical needs.

Child's Name:		D.O.B:	
Plan Implementation Date:		Review Date:	
Medical Practitioner Name:		Phone:	

<table>
<tr><td>Diagnosed medical condition:</td><td>Details, symptoms and triggers of medical condition:</td></tr>
<tr><td></td><td rowspan="2"></td></tr>
<tr><td>Photo of Child</td></tr>
<tr><td rowspan="2"></td><td>Step by step action to be taken:</td></tr>
<tr><td></td></tr>
<tr><td>Parent/Guardian contact details:</td><td>Medication to be administered (name of medication, dose and method of application, frequency of application, further instructions.)</td></tr>
<tr><td>Name:
Mobile:
Work Phone: Home:
Signature:
Date:</td><td></td></tr>
<tr><td>Parent/Guardian contact details:</td><td>Steps to take if symptoms do not improve</td></tr>
<tr><td>Name:
Mobile:
Work Phone: Home:
Signature:
Date:</td><td></td></tr>
</table>

Medical Practitioners Signature: _____ Date: _____

Nominated Supervisor Signature: _____ Date: _____