

# MEDICAL RISK MINIMISATION PLAN

<b>CHILD'S NAME:</b>		<b>DOB:</b>
1. Details of medical condition?		
2. Does the child need dietary modifications? <i>(If yes, please comment in sections below.)</i>	Y/N	3. Has a medical management plan been submitted for this condition?
	Y/N	
4. <b>RISK:</b> What are the issues or triggers <i>and/or</i> actual/potential situations that could lead to a medical emergency?		
5. <b>STRATEGY:</b> What can be done to reduce these risks? What resources are needed?		
6. <b>WHO:</b> Who needs to be included in the process? Why?		
<b>Dietary Modification: Unsafe foods &amp; meals: (If applicable)</b>		
<b>Safe foods &amp; meals: (If applicable)</b>		

Educator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nominated Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

All relevant staff members have been made aware of this plan and understand the risk, plan to minimise the risk and how to respond if a risk has been detected.