

# Medical Management Plan

**Child's Name:** ..... **Child's Date of Birth:** ...../...../.....  
**Plan Implementation Date:** ...../...../..... **Next Review Date:** ...../...../.....

This plan must be recompleted at least annually, and updated with any changes as required.

**Details of Child's Condition** (Condition, symptoms and triggers)

- .....
- .....
- .....
- .....
- .....

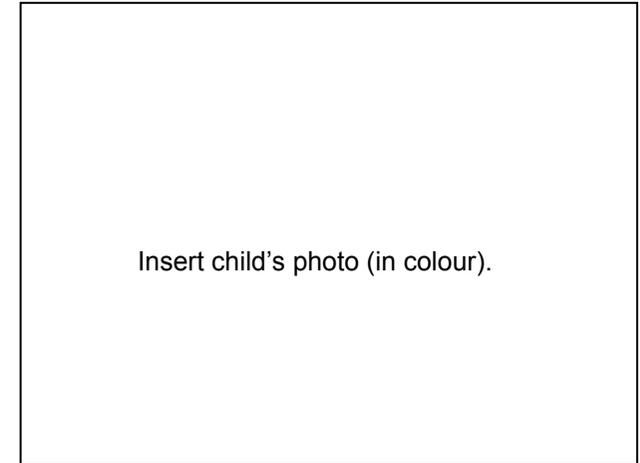
**Risk Minimisation Plan** (Steps to be taken to minimise risk or exposure, including medication to be administered)

- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

**Location of Medication:**.....

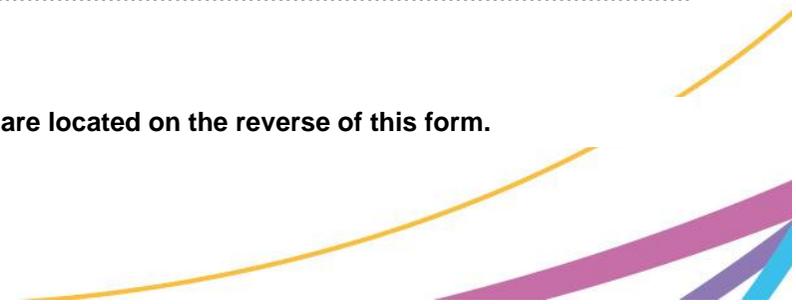
**Action Plan** (Step by step actions to be taken)

- .....
- .....
- .....
- .....



<b>DOCUMENT NUMBER &amp; TITLE</b>		NQS2 Medical Management Plan APPENDIX	
<b>POLICY OWNER</b>	Stan Coulter, General Manager, Governance and Risk	<b>CONTENT OWNER</b>	Sara Meredith, Child Wellbeing Manager, Quality
<b>DATE PUBLISHED</b>	12/12/2013	<b>DOCUMENT VERSION</b>	V6.0
		<b>REVISION DUE DATE</b>	12/12/2015
<b>RECORD MANAGEMENT SCHEDULE</b>	Child Enrolment - C+3yrs		
Ensure you are using the latest version of this policy. You can find it at <a href="http://policies.goodstart.org.au/PoliciesandProcedures/NQS2%20Medical%20Management%20Plan%20APPENDIX.docx">http://policies.goodstart.org.au/PoliciesandProcedures/NQS2%20Medical%20Management%20Plan%20APPENDIX.docx</a>			
Warning – uncontrolled when printed. This document is current at the time of printing and may be subject to change without notice.			

**Emergency contact details are located on the reverse of this form.**



**Parent/Guardian**

Name: .....  
 Mobile: .....  
 H: ( ) ..... W: ( ) .....  
 Signature:..... Date:...../...../.....

**Parent/Guardian**

Name: .....  
 Mobile: .....  
 H: ( ) ..... W: ( ) .....  
 Signature:..... Date:...../...../.....

This plan is to be displayed in an area accessible by staff who are responsible for your child's education and care. Your plan will be displayed in the..... To comply with the Education and Care Services National Regulations your consent is required. This information will not be used for any purpose other than to ensure the wellbeing of your child.

Name: ..... Signature:..... Date:...../...../.....

**Medical Practitioner**

Name: .....

B: ( ) ..... W: ( ) ..... Signature:..... Date:...../...../.....

Documentation provided by Medical Practitioner (attached):  
 .....

Please note: A separate medical management plan is to be provided by a Medical Practitioner for Diabetes and Epilepsy which must include a detailed action plan for the management and treatment of these conditions.

Communication Plan	Date
•Relevant staff and volunteers have been informed about Goodstart's Medical Conditions Requirement.	
•Relevant staff and volunteers have been informed about this medical management plan and risk minimisation plan and know where to locate this plan in the case of an emergency, refer to Medical Management Plan Informed Consent.	
•Goodstart's Medical Conditions Requirement has been provided to the family.	

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