

Medical information

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a child/student/client who requires individual health and personal care support. Some condition-specific forms are also available.

This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Description of the condition

Observable signs and symptoms _____

Frequency and severity _____

Triggers (if applicable) _____

Possible impact on activities (eg physical activity, camps, excursions, kitchen, laboratory or workshop activities, interrupted attendance)

First Aid

If a child/student/client becomes ill or is injured, supervising staff will administer first aid and call an ambulance if necessary.

If you anticipate this child/student/client will require anything other than a standard first aid response, please provide detailed written recommendations so special arrangements can be negotiated.

Additional information attached to this care plan

Medication authority (if supervision of medication is recommended while in education or child/care)

Individual first aid plan (if different to standard first aid—see model over page)

General information about this person's condition

Other (please specify) _____

This plan has been developed for the following services/settings: *

School/education

Child/care

Respite/accommodation

Transport

Outings/camps/holidays/aquatics

Work

Home

Other (please specify)

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

Telephone _____

Signature _____ Date _____

**I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.**

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

Individual first aid plan

for education, child/care and community support services*

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To be completed by the HEALTH PROFESSIONAL and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a child/student/client who requires individual first aid assistance.
Standard first aid plans (for a range of conditions) can be found at [Pathways](#) on the *chess* website www.chess.sa.edu.au.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MediAlert Number (if relevant) _____ Date for next review _____

The child/student/client has a medical condition described as _____

And will require the following first aid response when these symptoms/reactions are observed.

Observable sign/reaction	First aid response
<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>
<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>
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This plan has been developed for the following services/settings: *

- | | |
|--|--|
| <input type="checkbox"/> School/education | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care | <input type="checkbox"/> Work |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (please specify) |

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

Telephone _____

Signature _____ Date _____

**I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.**

Parent/guardian or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)