Health support plan

A risk minimisation form for education, child care and community support services

CONFIDENTIAL

To be completed by the PRINCIPAL, DIRECTOR or HOME-BASED CARE PROVIDER, with the FAMILY and OTHERS as indicated below, for a child/student/client who requires individual health and personal care support in school, preschool or child care. This plan should be based on written health care advice from a health professional. It will involve risk assessment for staff in planning for the child/student/client.

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

Worksite name			
Name of child/student/client _	Family name (please print)	First name (please print)	Date of birth
			dcare services to complete a health
			gical health support needs. These inks/Notes_re_HSP_July_16_2012.doc
Care plans and other	er documentation	n such as medical rep	orts
Does the child/student/	client have any doc	uments describing his/he	er health care needs? 🗆 Yes 🗆 No
☐ Acquired brain injury	care plan	☐ Cont	inence care plan
☐ Allergy/anaphylaxis ca	are plan	☐ Oral	eating and drinking care plan
☐ Asthma care plan		☐ Tran	sfers and positioning care plan
☐ Cystic fibrosis care pla	an	☐ Medi	cation authority
☐ Diabetes care plan		☐ Gene	eral health information form
☐ Modified diet care pla	n	☐ Medi	ical information form
☐ Oncology patient care	e plan	☐ Nego	otiated education plan
☐ Osteogenesis imperfe	cta care plan	☐ Beha	aviour management plan
☐ Seizure care plan		□	
☐ Spina bifida and hydro	ocephalus care plan	□	
Complex/invasive h	ealth support		
Does the child/student/	client have complex	/invasive health care ne	eds?
(eg gastrostomy or other tube	feeding; postural drainag	e; routine oxygen; tracheostom	y care; catheter/stoma management)
First aid			
Is there any individual f	irst aid requirement	, other than a basic first	aid response? ☐ Yes ☐ No
(eg in relation to asthma; anap prescribed intranasal midazola			via an auto-injector); administration of

Douting supervision for health save veleted safety
Routine supervision for health care-related safety
Is there a known recommendation for additional supervision for health care-related safety? Yes No (eg a medication authority for administration during times when the child/student/client is in the care of staff; strategies for allergy management; diabetes monitoring; identified risk of self-harm or a diagnosed mental disorder including anxiety or symptoms that interfere with participation in the program; illness-related problems)
Personal care
Personal care
Is there a need for additional support with daily living tasks? ☐ Yes ☐ No
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Other considerations

siblings, peers, o (eg related to psychol deteriorating health; g	r others involved in the studen logical wellbeing; interrupted attendand prief and loss issues; palliative care)	t's care? re; learning in other setting	wellbeing of the child/student/clie Yes	No
Who, apart from	Agree	ting will have a copy	of this plan?	
1		Role		
2		Role		
3		Role		
3		Role		
Principal/director or care provider	amily name (please print) First name (please print)	Signature	Date	
Staff/contact person (if relevant)	amily name (please print) First name (please print)	Signature	Date	
Authorisation				
	erstood and agreed with this p this plan by supervising staff.	lan and any attachme	ents indicated above.	
Parent/guardian or adult student/client	Family name (please print) First name (please	Signature	Date	
Child/student			Date	