Holy Eucharist Catholic Primary School

1a Oleander Drive St Albans, VIC 3021
Ph: 8312 0900

INDIVIDUAL MEDICAL MANAGEMENT PLAN FOR _____

(Please list Medical Condition)

NB: This form is to be used for all medical conditions including allergies (not asthma or anaphylaxis).
For students with:

- *Asthma - Please complete the Asthma Care Plan*
- *Anaphylaxis – Please complete Individual Anaphylaxis Management Plan*

This plan is to be completed by the Principal or nominee on the basis of information from the student's medical practitioner provided by the Parent.

It is the Parents' responsibility to provide the School with a copy of the student's Medical Action Plan for _____ containing the emergency procedures plan (signed by the student's Medical Practitioner) and an up-to-date photo of the student - to be appended to this plan; and to inform the school if their child's medical condition changes.

School Holy Eucharist School	**Student's Name:**
Student's Date of Birth:	**Student's Year Level:**
Medicare No:	**Health Insurance No:**
Ambulance Cover: ☐ Yes ☐ No	**Ambulance Membership No:**

Emergency Contact Details (Parents)

Name		**Name**	
Relationship		**Relationship**	
Home phone		**Home phone**	
Work phone		**Work phone**	
Mobile		**Mobile**	
Address		**Address**	

Emergency Contact Details (An alternative to parents)

Name	
Relationship	
Home phone	
Work phone	
Mobile	

Medical Practitioner

Medical Practitioner Contact:	**Name:**	
	Address:	**Phone**
Please list Medical Plan – this needs to include information for when the child is ill. **(Please attach further information – if needed)**		

Symptoms which may be displayed in the event of an emergency	
Other health issues /conditions	
Is medication needed at school?	
If Yes, what medication is to be given? (Parent will need to fill in Medication Authority Form)	
Doctor Details	Name of Doctor _____ Address _____ Phone _____ Doctor's Signature _____ Date _____

Environment

To be completed by Principal or nominee. Please consider each environment/area (on and off school site) the student will be in for the year, e.g. classroom, canteen, sports oval, excursions and camps etc.

Name of Environment/Area:

Risk identified	Actions required to minimise the risk	Who is responsible?	Completion date?

Name of Environment/Area:

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Name of Environment/Area:			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of Environment/Area:			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**

This individual Medical Management Plan will be reviewed on any of the following occurrences (whichever happens earlier):

- Annually
- if the student's medical condition changes ;
- when the student is to participate in an off-site activity, such as Camps and Out of School Activities (excursions), or at special events conducted, organised or attended by the School (eg. Cultural days, incursions, family fun days)

Parent / Guardian	
I have read, understood and agree with this Medical Care Plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.	
Signature:	**Date:**
Name:	

Principal (or nominee)			
I have consulted with the Parents of the student and the relevant School Staff who will be involved in the implementation of this Medical Management Plan.			
Signature of Principal (or nominee)		**Date**	
Name			