Hahndorf

OUT OF SCHOOL HOURS CARE

MEDICAL CONDITIONS RISK MINIMISATION PLAN

Parent/guardian to complete:	
Child's Name:	**Date of Birth:**
1. What is the specific health care need, allergy or relevant medical condition that this assessment addresses?	
2. Does the child need dietary modifications? (If Yes, please comment in the sections below)	
3. **Risk** – What are the issues and / or the actual / potential situations that could lead to a medical emergency?	
4. **Strategy** – What can be done to reduce these risks? What resources are needed?	
5. **Who** – Who needs to be included in the process? Why?	
Unsafe foods and meals (if applicable):	
Safe foods and meals (if applicable):	

Name: _____ (nom supervisor) Date: _____

Signed: _____ (staff member)

Name: _____ (parent) Date: _____

Signed: _____ (parent)

I consent to the display my child's photo and medical management plan in the service: …….. (parent)

12 Church Street, Hahndorf SA 5245

Tel: 08 8388 7420 Fax: 08 8388 7928

email: oshc.hps382@schools.sa.edu.au website: www.hahndorfps.sa.edu.au

All educators have been made aware of this medical risk minimisation plan and understand the risk, plan to minimise the risk and how to respond if a risk has been detected.

SERVICE MEDICAL PLAN	**Photo ID:**
Child's Name:	
Date of Birth:	
SERVICE TO COMPLETE based on the information provided by the family :	
1. Health care need, allergy or relevant medical condition that this assessment addresses?	
2. **What are the potential risks from our perspective** –	
3. **Strategies to address risks –**	
4. **Who** – Who needs to be included in the process? Why?	

Name: _____ (staff member) Date: _____

Signed: _____ (staff member)

All educators have been made aware of this medical risk minimisation and service plan, and understand the risk, plan to minimise the risk and how to respond if a risk has been detected.

Nominated Supervisor's signature: _____ Date: _____

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Review date:

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