

Heart Health Care Plan

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, First name

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

Description of the condition

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

- _____
- _____
- _____
- _____
- _____
- _____

Signs and symptoms (Note: this list indicates the severity of the symptoms. If an ambulance is called the parents/emergency contacts will always be notified.)

Call an ambulance

call the parents/emergency contacts

Pale

Fatigue

Bruises/abrasions

Apparent high temperature

Breathless

Cough

Blue colour

Dizzy

Fainting

Chest pain

Broken Bones

Severe breathing difficulties

Unconscious

Collapse

If a child collapses/falls unconscious/ experiences severe breathing difficulties/breaks any bones standard emergency first aid will be administered and an ambulance called.

If it is anticipated that this child/student/client will require anything other than a standard first aid response, detailed written recommendations (e.g. individualised first aid flow chart) need to be provided so special arrangements can be negotiated.

Frequency and severity

Exacerbating factors (if applicable)

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

Any other considerations (e.g. infection control, extreme weather)

Additional information

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

- _____
- _____

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 roll: _____

Address: _____

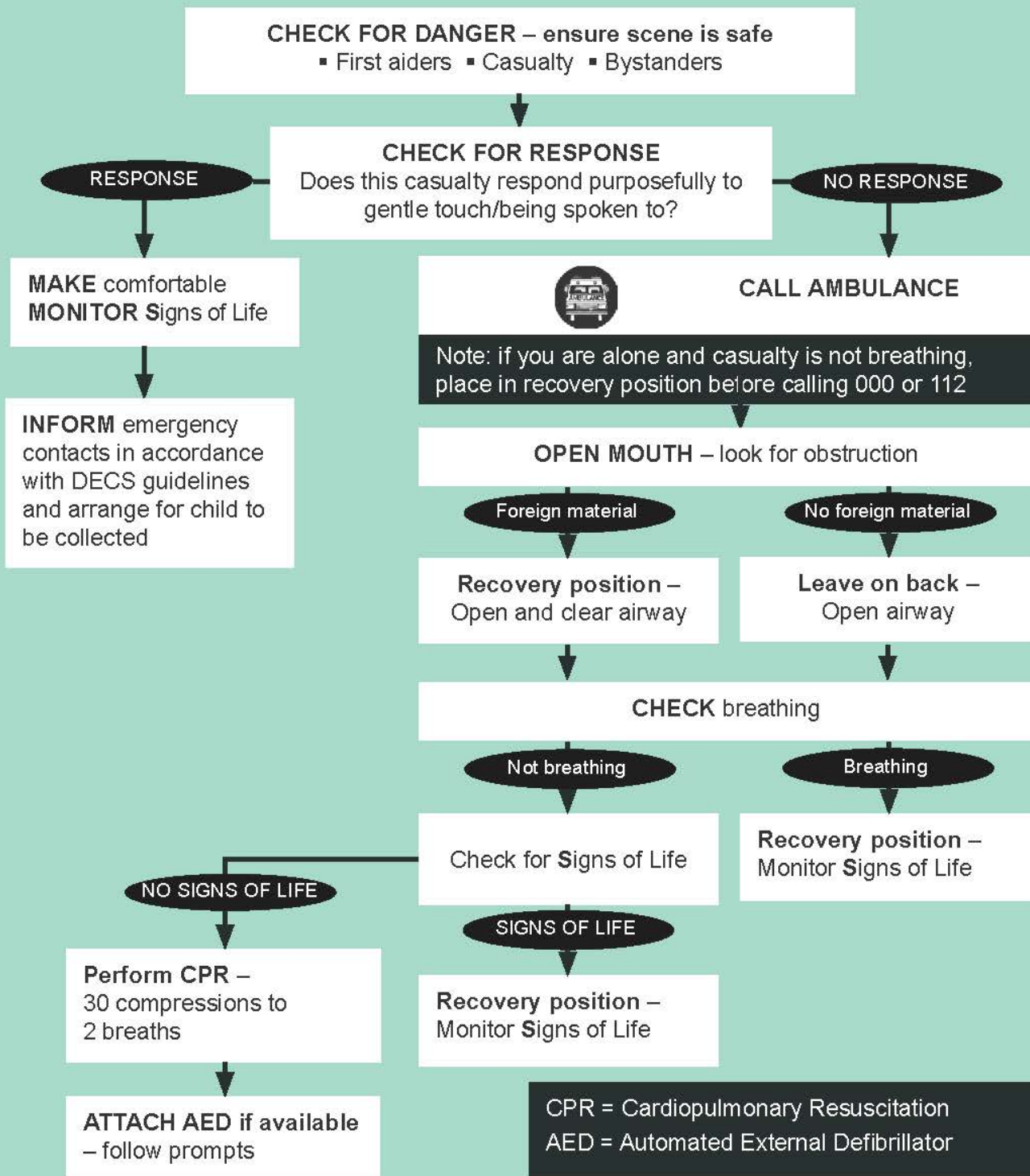
Telephone: _____

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)

Collapse



TO CALL AMBULANCE: Dial out, then 000 or mobile 112
Say what state you are calling from, the person's condition and location



INFORM EMERGENCY CONTACTS in accordance with DECD guidelines