Government of South Australia
Department for Education

Non-specific Health Care Plan

for education and care

CONFIDENTIAL

To be completed by the treating medical professional and parent or legal guardian for a child or young person requiring additional care or supervision related to their physical or mental health and wellbeing.
(Note: other proformas are available for more specific health care plans)
This information is confidential and will be available only to relevant staff and emergency medical personnel.

Affix photo of child / young person

Name of child/young person:

DOB: **MedicAlert #:**

Date developed: **Review date:**

Allergies:

DESCRIPTION OF THE CONDITION

It is not necessary to provide a full medical history. Education and care staff only need to know information relevant to the child or young person's attendance, learning and wellbeing in education and care settings.

IMPLICATIONS FOR EDUCATION AND CARE SETTINGS

Only include information that is relevant for supervising staff to teach and care for the child or young person (for example):

☐	Impact on capacity to attend and participate in routine learning activities
☐	Limitations on physical activity
☐	Need for rest and/or privacy
☐	Need for additional emotional support
☐	Behaviour management plan
☐	Considerations for camps, excursions, social outings

Provide details

NON-SPECIFIC HEALTH CARE PLAN
Health Support Planning

DESCRIPTION OF WARNING SIGNS, TRIGGERS, CIRCUMSTANCES AND RECOMMENDED RESPONSE

ADDITIONAL INFORMATION

AUTHORISATION AND AGREEMENT

(To be signed after form has been completed)

The following settings have been considered in the development of the health care plan and is appropriate for use in the following:

☐	Children's centre, preschool or school	☐	Childcare, Out of School Hours Care
☐	Camps, excursions, special event, transport (incl. aquatics)	☐	Work experience or other education placement
☐	Respite, accommodation	☐	Work
☐	Transport	☐	Other (specify)

Treating medical professional

(name)	(professional role)
(address)	(telephone)
(signature)	(date)

Parent or legal guardian; or adult student

- **I understand and agree with the health care plan as indicated above**
- **I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).**
- **I understand staff may seek additional information and/or advice regarding the medical information contained in the individual first aid plan from the Access Assistant Program (AAP) to inform duty of care.**

(name)	(relationship)
(signature)	(date)