Government of South Australia

Non-specific Health Care Plan

for education and care

CONFIDENTIAL

To be completed by the treating health 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.

Name of child/young person:

DOB: Review date:

Allergies:

Education or care service:

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.

Provide details

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

DESCRIPTION OF WARNING SIGNS, TRIGGERS, CIRCUMSTANCES AND RECOMMENDED RESPONSE

Provide details

ADDITIONAL INFORMATION

Provide details

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 health professional

Print name & practice/hospital or stamp	Professional role
	Email or signature
Telephone	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
Email or signature	Date