

Personal & Confidential

Medical/Health Information and Action Plan Form

Section 1 – Young Persons Details

TITLE (Mr, Mrs, Ms, Miss)	SURNAME/FAMILY NAME	GIVEN NAME	MIDDLE NAME	PREFERRED NAME
---------------------------	---------------------	------------	-------------	----------------

Section 2 – Parent or Guardian Details

TITLE (Mr, Mrs, Ms, Miss)	SURNAME/FAMILY NAME	GIVEN NAME	MIDDLE NAME	PREFERRED NAME
---------------------------	---------------------	------------	-------------	----------------

Section 3 - Asthma Action Plan (if applicable)

Please attach the young person's Asthma Action Plan provided by your General Practitioner

Section 3b – Asthma Action Plan - Symptoms

Usual signs and symptoms	If applicable	Worsening signs and symptoms	If applicable
Wheezing	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
Tightness in chest	<input type="checkbox"/>	Tightness in chest	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	Coughing	<input type="checkbox"/>
Difficulty in breathing	<input type="checkbox"/>	Difficulty in breathing	<input type="checkbox"/>
Difficulty in speaking	<input type="checkbox"/>	Difficulty in speaking	<input type="checkbox"/>
Other specify	<input type="checkbox"/>	Other specify	<input type="checkbox"/>

Section 3c – Asthma Action Plan – First Aid Asthma Medication

Please tick the preferred First Aid Asthma plan. Note, if at any time the student's condition suddenly worsens or the staff are concerned an ambulance will be called immediately.

Asthma First Aid Section 4.5.7.8 of the Department of Education and Early Childhood Development Victorian Government Schools' Reference Guide

1. Sit the young person down and remain calm to reassure them. Do not leave the young person alone.
2. Without delay shake a blue reliever puffer (Aiomir, Asmol, Epaq or Ventolin) and give 4 separate puffs through a spacer (use the puffer alone if a spacer is not available). Use one puff at a time and ask the young person to take 4 breaths from the spacer after each puff. A Bricanyl Turbuhaler may be used in First Aid treatment if a puffer and spacer is unavailable.
3. Wait 4 minutes. If there is no improvement, repeat steps 2 and 3.
4. If there is still no improvement after a further 4 minutes – call an ambulance immediately (dial 000) and state the young person is having breathing difficulties. Continuously repeat steps 2 and 3 while waiting for the ambulance.

Young Persons Asthma First Aid Plan (if different from above) attach Asthma Action Plan

Section 4a – Allergy Action Plan (if applicable)

Young person's awareness of specific triggers low <input type="checkbox"/> moderate <input type="checkbox"/> high <input type="checkbox"/>	How to tell an adult about potential triggers _____ _____
Please list early signs of allergy symptoms _____ _____	When to tell an adult about potential triggers _____ _____

Section 4b – Allergy Action Plan – Symptoms

Allergy (please list)	Exposure		Severity	Symptoms	Treatment provided to the young person when exposed to the allergen		
	Touch <input type="checkbox"/> Inhalation <input type="checkbox"/>	Ingestion <input type="checkbox"/> Other <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>		Medication <input type="checkbox"/> (complete section)	Ambulance required <input type="checkbox"/>	Other <input type="checkbox"/> (Specify)
	Touch <input type="checkbox"/> Inhalation <input type="checkbox"/>	Ingestion <input type="checkbox"/> Other <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>		Medication <input type="checkbox"/> (complete section)	Ambulance required <input type="checkbox"/>	Other <input type="checkbox"/> (Specify)
	Touch <input type="checkbox"/> Inhalation <input type="checkbox"/>	Ingestion <input type="checkbox"/> Other <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>		Medication <input type="checkbox"/> (complete section)	Ambulance required <input type="checkbox"/>	Other <input type="checkbox"/> (Specify)
	Touch <input type="checkbox"/> Inhalation <input type="checkbox"/>	Ingestion <input type="checkbox"/> Other <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>		Medication <input type="checkbox"/> (complete section)	Ambulance required <input type="checkbox"/>	Other <input type="checkbox"/> (Specify)
	Touch <input type="checkbox"/> Inhalation <input type="checkbox"/>	Ingestion <input type="checkbox"/> Other <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>		Medication <input type="checkbox"/> (complete section)	Ambulance required <input type="checkbox"/>	Other <input type="checkbox"/> (Specify)

Section 5a – Epilepsy Action Plan (if applicable) Please attach plan

Awareness of specific triggers low <input type="checkbox"/> moderate <input type="checkbox"/> high <input type="checkbox"/>	How to tell an adult about potential triggers _____ _____
Early signs of epilepsy symptoms _____ _____	When to tell an adult about potential triggers _____ _____

Section 5b – Epilepsy Action Plan – Neurologists Details

Practice Name	Contact Number
Doctors Full Name	Address

Section 5c – Epilepsy Action Plan – Seizures

Type of seizure	Characteristics of seizure
Behaviour before seizure	Behaviour after seizure
Care during seizure	Usual duration of seizure
When should an ambulance be called	Usual hospital that has provided treatment

Section 6a – Medication Authorisation - Principles

Staff are NOT permitted to administer medication.	Non-invasive emergency medication is provided as noted in a provided action plan.
Each medication dose provided must be documented on the form.	
Invasive emergency medication is only to be administered by a paramedic or doctor.	

Section 6b – Medication Authorisation - Expectations

Before program delivery

<ul style="list-style-type: none">• Ensure this medication form is fully completed. (See Section 9)	<ul style="list-style-type: none">• Allocate staff member to monitor taking of medication	<ul style="list-style-type: none">• Place medication and form in the program bag
<ul style="list-style-type: none">• Medication must have a certified pharmacists label	<ul style="list-style-type: none">• Webster medication packs must be labelled from a pharmacy with name, date, dose, frequency and medication name.	<ul style="list-style-type: none">• Discuss the details of how the staff member will monitor the young persons administering their own medication.

During program delivery

- Ensure a staff member monitors the taking of the medication to the young person where possible.
- If a medical emergency occurs the parent/guardian must be immediately contacted and informed of all the relevant details.

After program delivery

- Any unused medication must be returned to the parent/guardian when the program has ended each day.

Section 7 - Behaviour

Are there any known behavioural concerns? If so please list: Yes No

Section 8 - Privacy Collection, Use and Disclosure Statement

Your personal and health information is being collected by Council for the purposes of you consenting to your or (your child's) attendance at the excursion, and will only be disclosed to Council staff involved in facilitating the excursion:

- Ensure young people are supported during specific program and general service delivery;
- Ensure parents/grandparents/guardians/workers or emergency contacts can be easily contacted if required;
- Assist Youth Services with strategic program and service planning, delivery and evaluation;
- Create an opportunity to provide you with promotional material about the services and programs.

Your information will be stored in Council's Customer Database and used to identify you when communicating with Council and for Council to deliver services and information to you.

The information you provide shall remain private within Council unless disclosure is permitted by law, or consented to by you. You may apply for access and/or amendment of the information by writing to the Council's Privacy Officer.

For further information on how your personal and health information will be handled, refer to Council's Privacy Policy at:

www.wyndham.vic.gov.au/privacy-policy

It is assumed that all emergency contacts listed have been notified and have given permission for their details to be provided. Youth Services staff shall enter this information into a database for data collection.

Agreement on your Responsibilities and Information

I agree and consent to:

- Provide permission for the young person to attend the Wyndham City program or service,
- Accept the conditions noted in the section for 'Responsibilities and Expectations', read and explained the conditions to the young person (if under 18 years) and they also understand and accept these conditions,
- Consent to the collection and use of information as noted in the 'Privacy Collection Statement' section,
- Accept that when a Power of Attorney is in place, Council will share any personal information about or shared by the young person with the guardian,
- Disclose any Power of Attorney arrangements to Council that is entered into while I am accessing Council services.

I _____ (name) young person over 18 or the parent/guardian/grandparent/worker of

_____ (Young person's name if under 18) hereby sign _____ (signature) to state my

acceptance and consent to the points outlined above on ____/____/____ (date).

Office use only

NAR <input type="checkbox"/>	CRM <input type="checkbox"/>	Scanned <input type="checkbox"/>	Filed in CRM <input type="checkbox"/>	Objective <input type="checkbox"/>	Provided young person with additional information if indicated from the 'Services and Programs' section <input type="checkbox"/>
------------------------------	------------------------------	----------------------------------	---------------------------------------	------------------------------------	--

Section 7 – Medication Details

Parents or Guardians					Staff							
Date	Medication name	Dosage and instructions	Date and time of last dose	Time/s to be given	Date	Time	Correct medication	Correct dosage	Checked by	Assisted by	Young persons signature	

Parent / Guardian Authorisation

I authorise Wyndham Youth Services staff to assist my child to administer necessary prescribed medication during program delivery. There are to be no amendments to the medication requirements documented in this form, if medication requirements change a new form must be completed. **I understand that the staff cannot give an injection or purchase or supply any medication to my child.** I agree that in the event of an emergency or where the parents or guardian cannot be contacted that the Wyndham City staff member may organise such medical attention as deemed necessary and I will pay all costs of such medical attention. All Wyndham City staff are free and clear of any responsibilities and liabilities whatsoever in supervising the young person self-administering their medication.

I _____ (Parent / Guardian's name) the parent/grandparent/guardian/worker of _____ (young person's name) hereby sign

_____ (signature) to state my acceptance and consent to the points outlined above on _____ / _____ / _____

