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| **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 | | □ | | Wheezing | | □ | |
| Tightness in chest | | □ | | Tightness in chest | | □ | |
| Coughing | | □ | | Coughing | | □ | |
| Difficulty in breathing | | □ | | Difficulty in breathing | | □ | |
| Difficulty in speaking | | □ | | Difficulty in speaking | | □ | |
| Other specify | | □ | | Other specify | | □ | |
| **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 (Airomir, 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** | | | | | | | |
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**Personal & Confidential**

**Medical/Health Information**

**and Action Plan Form**

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| **Section 4a – Allergy Action Plan (if applicable) □** | | | | | | | | | |
| Young person’s awareness of specific triggers  low □ moderate □ high □ | | | | | 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 □  Inhalation □ | Ingestion □  Other □ | Mild □  Moderate □  Severe □ |  | | | Medication □  (complete  section ) | Ambulance required □ | Other □  (Specify) |
|  | Touch □  Inhalation □ | Ingestion □  Other □ | Mild □  Moderate □  Severe □ |  | | | Medication □  (complete  section ) | Ambulance required □ | Other □  (Specify) |
|  | Touch □  Inhalation □ | Ingestion □  Other □ | Mild □  Moderate □  Severe □ |  | | | Medication □  (complete  section ) | Ambulance required □ | Other □  (Specify) |
|  | Touch □  Inhalation □ | Ingestion □  Other □ | Mild □  Moderate □  Severe □ |  | | | Medication □  (complete  section ) | Ambulance required □ | Other □  (Specify) |
| **Section 5a – Epilepsy Action Plan (if applicable) Please attach plan** | | | | | | | | | |
| Awareness of specific triggers low □ moderate □ high □ | | | | | 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. | | | | | | | | | |

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| **Section 6b – Medication Authorisation - Expectations** | | |
| Before program delivery | | |
| * Ensure this medication form is fully completed. (See Section 9) | * Allocate staff member to monitor taking of medication | * Place medication and form in the program bag |
| * Medication must have a certified pharmacists label | * Webster medication packs must be labelled from a pharmacy with name, date, dose, frequency and medication name. | * 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](http://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.** | | |

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| **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 □ | CRM □ | Scanned □ | Filed in CRM □ | Objective □ | Provided young person with additional information if indicated from the ‘Services and Programs’ section □ |

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| **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 |
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| **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 \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |