BRIGHT HORIZONS AUSTRALIA CHILDCARE

MEDICAL CONDITIONS & MANAGEMENT PLAN

Incl. Asthma, Allergy, Anaphylaxis & other

To assist with the safety and well being of your child please give detailed information below. Please attach any important additional information. This form is to be reviewed if your child's condition changes or every 6 months and a new updated plan provided every 12 months.

Child's Name: _____ Date: _____

Medical Condition: _____

MANAGEMENT PLAN

How often does your child display symptoms of/or is affected by their medical condition?

☐ Infrequently (less than 5 times/year) ☐ Frequently (more than 5 times/year) ☐ Most days/daily

What are the early signs and symptoms of your child's medical condition?

☐ Wheezing (whistling noise from chest) ☐ Difficulty with breathing ☐ Tightness in chest

☐ Itchiness ☐ Other: _____

What symptoms indicate your child's condition is worsening? _____

_____

What triggers your child's medical condition (if known)? _____

_____

Can your child recognise & communicate early signs of their condition? ☐ Yes ☐ No

MEDICATION

Does your child require regular/preventative medication whilst at childcare? ☐ Yes ☐ No

If yes, (under which circumstances) is their medication required? Please provide as much detail as possible: _____

REGULAR / PREVENTATIVE MEDICATION DETAILS (If applicable)		
Medication	**Method Used (inhaler, oral, topical)**	**Dose and Frequency**

What relief medication does you child normally take when symptoms worsen?

RELIEF MEDICATION DETAILS		
Medication	**Method Used (inhaler, oral, topical)**	**Dose and Frequency**

EMERGENCY ACTION PLAN - MEDICATION DETAILS (Refer to child's full Action Plan)		
Medication	**Method Used (inhaler, oral, topical)**	**Dose and Frequency**

☐ I have completed the relevant Action Plan with photo to submit with this form.

I have consulted with my child's doctor and authorise the staff at Bright Horizons Australia Childcare Centre to follow the Preferred Emergency Action Plan (indicated above) to assist my child in the event of the condition's symptoms worsening. I will notify you in writing using the changes if there are any changes to these instructions. Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms. Educators will complete the medication administration form.

Parents/Guardians Name: _____ **Signature:** _____ **Date:** _____

Parents/Guardians Emergency Contact Numbers: _____

Medical Practitioner (Doctor/Specialist): _____

Signature: _____ **Contact Number:** _____ **Date:** _____