Heart Health Care Plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a child/student/client who requires individual health and personal care support. Some condition-specific forms are also available. This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client:		Date of birth:
	Family name,	First name
MedicAlert Number (if relevant): _		Date for next review:
Description of the cond	dition	
The child/student/client has a medi	ical condition described as	and is:
•		
•		
•		
•		
Signs and symptoms (Note: this	list indicates the severity	of the symptoms. If an ambulance is called the parents/emergency
contacts will always be notified.)		
	Call an ambulance	call the parents/emergency contacts
Pale		
Fatigue		
Bruises/abrasions		
Apparent high temperature		
Breathless		
Cough		
Blue colour		
Dizzy		
Fainting		
Chest pain		
Broken Bones Severe breathing difficulties		pses/falls unconscious/ experiences severe breathing any bones standard emergency first aid will be administered called.
Unconscious		this child/student/client will require anything other than a standard ailed written recommendations (e.g. individualised first aid flow chart)

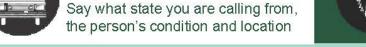
need to be provided so special arrangements can be negotiated.

Frequency and severity

Collapse

Exacerbating factors (if applicable)		
Possible impact on activities (eg physical activity, camps, excu	rsions, kitchen, laboratory or workshop activities	s, interrupted attendance)
Any other considerations (e.g. infection control, extreme weath	er)	
. ,	,	
Additional information		
First Aid		
FIISTAIU		
If a child/student/client becomes ill or is injured, supervising st		
If you anticipate this child/student/client will require anything recommendations so special arrangements can be negotiated.	other than a standard first aid response, p	lease provide detailed written
Additional information attached to this	care nlan	
Additional information attached to time	ouro pian	
•		
•		
This plan has been developed for the following services	c/cattings: *	
School/education	Outings/camps/holidays/aquatics	
Child/care	Work	
Respite/accommodation Transport	Home Other <i>(please specify)</i> :	
AUTHORISATION AND RELEASE	Other (please specify).	
AUTHORISATION AND RELEASE		
Health professional:	Professional roll:	
Address:		
Telephone:		
·	D-4-	
Signature	Date:	
I have read, understood and agreed with this plan and any atta I approve the release of this information to supervising staff at		
Parent/guardian		
or adult student/client	Signature	Date
Family name (please print) First name (please	se print)	

Collapse CHECK FOR DANGER - ensure scene is safe First aiders Casualty Bystanders CHECK FOR RESPONSE RESPONSE NO RESPONSE Does this casualty respond purposefully to gentle touch/being spoken to? MAKE comfortable **CALL AMBULANCE** MONITOR Signs of Life Note: if you are alone and casualty is not breathing, place in recovery position before calling 000 or 112 **INFORM** emergency contacts in accordance **OPEN MOUTH** – look for obstruction with DECS guidelines and arrange for child to Foreign material No foreign material be collected Leave on back -Recovery position -Open and clear airway Open airway **CHECK** breathing Not breathing Breathing Recovery position -Check for Signs of Life Monitor Signs of Life NO SIGNS OF LIFE SIGNS OF LIFE Perform CPR -Recovery position -30 compressions to 2 breaths Monitor Signs of Life CPR = Cardiopulmonary Resuscitation ATTACH AED if available AED = Automated External Defibrillator - follow prompts TO CALL AMBULANCE: Dial INFORM EMERGENCY out, then 000 or mobile 112





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