Our Lady of Hope Greenwith OSHC Health Support Procedure

Health support planning in education and care promotes attendance and positive engagement in the curriculum regardless of a child or young person's health status.

Health Support planning at OSHC is a requirement for families who have a child/ren with a disability or medical condition. The OSHC is an inclusive and diverse environment and will require detailed information from families and medical practitioners to ensure adequate care can be given.

Confidentiality

Health and personal care information is confidential and only provided to staff that are supporting the child or young person and emergency services (if required).

Health care plans

Health care plans are completed by treating health professionals to describe individual care recommendations. The next page provides links to individual care plans, first aid plans and medication agreements.

Managing health in education and care

A health profile is to be completed by parents/guardians on enrolment to provide education and care services a summary of health support requirements for their child or young person.

STEPS FOR FAMILIES FOR A CHILD WITH A HEALTH/MEDICAL CONDITION

1. Complete a health profile form (pg. 5)

2. Download relevant template of health/medical condition from the Department of Education website (if applicable) Specific health conditions and needs (education.sa.gov.au)
*If your child has a modified diet, please fill in the modified diet care plan (pg. 6)

3. Complete form in full with a doctor, include a photo of your child and a start and review date.

*Please ensure if your child requires medication at OSHC the medication agreement below (pg. 7) is completed in full and signed by a medical practitioner and has a **start** and **review** date

Please note: All medications require prescription with a chemist label on both the box and the bottle with your child's name, doctors full name, name of medication, dosage and expiry date. Medication must match the signed action plan/medication agreement that is completed in full by your doctor. Your child's medication will be stored at OSHC in an individual box with your child's name.

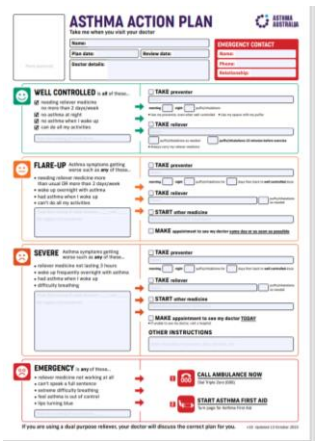
4. Scan and upload documents to Xplor or via email
    - Health profile form
    - Template of health/medical condition from department of education website
    - Medication agreement if your child requires medication
    - Any other relevant documentation of the child's health/medical condition (e.g. diagnosis report)

* Refer below for an example

5. An admin member will be in contact with you once your completed documentation has been received and will arrange a time to meet to complete your child's risk management and communication plan.

Example for a child with **ASTHMA**:

HEALTH PROFILE
for Early Childhood Education and Care (OSHC, Preschool & ELC)
CONFIDENTIAL


ASTHMA ACTION PLAN

ASTHMA FIRST AID
Blue/Grey Reliever

Medication Agreement Template
for Early Childhood Education and Care (OSHC, Preschool & ELC)
CONFIDENTIAL

Example for a child with **ADHD** who requires medication:

HEALTH PROFILE
for Early Childhood Education and Care (OSHC, Preschool & ELC)
CONFIDENTIAL

Medication Agreement Template
for Early Childhood Education and Care (OSHC, Preschool & ELC)
CONFIDENTIAL

Medication with chemist label

- Must match with medication agreement
- Childs name
- Doctors name
- Name of medication
- Dosage
- Expiry Date

ADHD diagnosis report

Example for a child who is **Coeliac**:

HEALTH PROFILE
for Early Childhood Education and Care (OSHC, Preschool & ELC)
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Modified diet care plan
for education, child/care and community support services*
CONFIDENTIAL

Checklist for my child to start attending OSHC:

- I have completed a health profile form
- I have completed the relevant health/medical condition form from the Department of Education website in full with a doctor which states a start and review date.
- I have filled in a modified diet care plan if my child requires a modified diet

Parent/Guardian Consent

As a parent/guardian to_____ I have followed the above steps. I understand that if the documentation provided does not have a start and review date and is not completed in full my child's enrolment for OSHC will not be processed.

I understand that all medications require prescription, child's name, doctors full name and expiry date. Medication will be stored at OSHC in an individual box with my child's name. I will ensure the chemist label on the medication matches with the action plan (name of medication, dosage and strength).

I understand if I fail to provide the correct medication, or my medication stored at OSHC expires my child will not be able to attend OSHC.

I understand that I must meet with OSHC staff prior to my child commencing to complete a risk minimisation and communication plan. These plans need to be reviewed yearly for my child to continue attending OSHC.

Signed_____**Date**_____

HEALTH PROFILE

for Early Childhood Education and Care (OSHC, Preschool & ELC)

CONFIDENTIAL

The following information must be completed by the parent/guardian and returned to OSHC as soon as possible. This information is confidential and will be available only to relevant staff and emergency medical personnel.

Name of child/young person:			
DOB:		Medic alert number:	
Allergies:			
Education or care service:		Year level:	

EMERGENCY CARE

If your child becomes ill or is injured staff will administer basic first aid.

If your child requires emergency medical help an ambulance will be called and your child's emergency contact will be notified.

HEALTH SUPPORT

(Identify if your child or young person's has any health care needs)

Personal Care		Physical Health		Neurodiversity	
☐	Continence	☐	Anaphylaxis and allergy	☐	ADHD
☐	Infection control	☐	Modified Diet	☐	Anxiety
☐	Oral eating and drinking	☐	Asthma	☐	Autism Spectrum
☐	Personal Hygiene	☐	Cerebral palsy	☐	Depression
☐	Transfer and positioning	☐	Cystic Fibrosis	☐	Eating disorders
☐	Wound and skin care	☐	Diabetes	☐	Emotional regulation
		☐	Osteogenesis Imperfecta	☐	FASD
		☐	Seizures & Epilepsy	☐	Oppositional Defiant Disorder
		☐	Spina bifida	☐	Sensory Processing Disorder
☐	Other(specify)				

Provide a copy of any health care plans, action plans or management plans completed by a health professional (these can be accessed on the Department for Education website) https://www.education.sa.gov.au/supporting-students/health-e-safety-and-wellbeing/health-support-planning

MEDICATION

Is medication required to be administered in an education or care service?	☐ YES	☐ NO

If yes, a medication agreement must be completed (please find attached below)

CONSENT

☐ The information I have provided is true and correct

☐ I understand it is my responsibility to keep the education and care service up to date with my child's health support information.

Name	Relationship to child/young person
Signature	Date

Modified diet care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR OR DIETITIAN and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This form is to be used where a person has special diet or fluid needs for a proven medical condition
(including a proven history of food allergy or intolerance)

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Review date _____

Description of special dietary or fluid needs.

_____

_____

Foods, fluids and substances that must be avoided.

_____

_____

Safe alternative foods that can be consumed if appropriate *(eg lactose free or soy products for lactose intolerance).*

_____

_____

Details of any special feeding routine *(eg at particular times or intervals for health reasons, or medications to be given with foods).*

_____

_____

In the case of food allergy/intolerance, what are the signs and symptoms?
Please indicate whether the person can report symptoms, the time period over which symptoms might emerge and the severity of the anticipated reaction.

_____

_____

First aid response to signs and symptoms of an allergic reaction/intolerance to a food or other substance.
Please complete the first aid action plan on the back of this form.
If the reaction is severe, an anaphylaxis care plan, including an emergency first aid response, will be required from the treating medical practitioner. http://www.allergy.org.au/content/view/10/3/

_____

_____

*** This plan has been developed for the following services/settings:**

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)

Medication Agreement Template

for Early Childhood Education and Care (OSHC, Preschool & ELC)

CONFIDENTIAL

This information is confidential and will be available only to relevant staff and emergency medical personnel and, if required, by the Regulatory Authority.
*Medication Agreements that are modified, overwritten or illegible will **NOT** be accepted.*
The legal guardian can complete the medication agreement authorising Early Childhood Education and Care (ECEC) service staff to administer medication as instructed. All sections of the 'Authorisation' section must be checked to confirm authorisation to administer in an ECEC service by the legal guardian. *A treating health professional may assist the legal guardian to complete this form.*
A registered health professional (i.e. medical consultant, specialist nurse, GP, Dentist) **must** complete the 'Agreement' section below for **all** medication, including any Controlled Drug (S8) (including morphine, dexamphetamine and codeine), where oxygen or insulin is required to be administered in education or care, or where pain relievers (paracetamol or ibuprofen) are required to be administered regularly or for more than 72 continuous hours,

PARENT/GUARDIAN TO COMPLETE:

ECEC service:			
ECEC email: (if known)			
Name of child or young person:			
Date of birth:		Date of next review:	
Allergies:			

MEDICATION INSTRUCTIONS

The medication instructions must match EXACTLY the pharmacy label on the medication or medication will not be administered

Medication name		**TIME(S)** *To be administered within ½ hour of specified time(s):*
Form *(liquid, tablet, capsule, lotion, oxygen, inhaler, injection)*	Route *(skin, oral, inhaled, gastrostomy, subcutaneous)*	
Strength *(mg or mg/ml)*	Dose *(the number of tablets or mls must be written)*	Start date
Other instructions for administration *(when not appropriate to administer; how to administer i.e. with food; any changes to medication prior to administration i.e. crushing)*		End date *Medication Agreement ceases to be valid as at this date. Not required for long term medication.*

AUTHORISATION AND RELEASE

☐	The medication documented above is required to be administered during attendance at the ECEC service.
☐	The medication documented above is NOT a Controlled Drug (S8), oxygen, insulin or pain relief that requires administration for more than 72 continuous hours (if it is yes, 'Agreement' section must be completed by a health professional).
☐	Where the medication is a prescription medication; the medication has been prescribed for a current health condition.
☐	I confirm this medication has been administered to my child previously (a first dose cannot be administered in an ECEC service).
☐	My child is well enough for school (no active fever, no diarrhoea or vomiting, able to eat and drink as per normal, enough energy to participate throughout the day) and if there is a change in my child's health condition I will be called to collect them.
☐	I understand the medication provided must have a pharmacy label that matches the information in the Medication Agreement or the medication will not be administered.
☐	I approve the release of this information to supervising staff, emergency personnel (if required) and (if required) to the Regulatory Authority.
☐	I authorise the medication as instructed above to be administered in the ECEC service setting.
☐	I certify the above statements are true and correct.

Legal guardian

First name (please print) Family name (please print)

Email address or signature:	Date:

AGREEMENT: REGISTERED HEALTH PROFESSIONAL TO COMPLETE *

☐	I agree the medication instructions as written above are appropriate for administration in the ECEC service setting
☐	I authorise delegation to the WCHN Access Assistant Program/RN Delegation of Care Program (if required)

(print name & practice/hospital or stamp)	Date	
	Professional role	
Telephone	Email address or signature	

*** This form must be completed by a Registered Health Professional for *all* medication, including Controlled Drugs (S8), oxygen, insulin or pain relief required to be administered regularly or for more than 72 hours).**