



Medical Management Plan

To be completed by your medical practitioner

Student's Name:	Photo:
Student's DOB:	Known allergies:
School Name:	School Location:
Year level:	Date of this plan: Date for review:
Is an interpreter required? Has cultural safety and/or cultural support been considered and offered if relevant?	
Copies of this Medical Management Plan are provided to 1. Student's Family 2. School: _____ 3. Other: _____	
Implications for education and care (indicate all applicable)	
<input type="checkbox"/>	Impact for attendance onsite at school
<input type="checkbox"/>	Impact on capacity to maintain attention or participate in routine educational activities
<input type="checkbox"/>	Limitations on mobility or physical activity, requires mobility support
<input type="checkbox"/>	Personalised Care and Support needs (toileting, feeding etc)
<input type="checkbox"/>	Requires a Behaviour Support Plan or additional supervision, flight risk, scalability assessment
<input type="checkbox"/>	Requires communication support or Augmentative and/or Alternative Communication
<input type="checkbox"/>	Requires complex care (catheterisation, STOMA care, tracheostomy care etc)
<input type="checkbox"/>	Consideration for camps, excursions, incursions or other activities
<input type="checkbox"/>	Consideration for transportation
<input type="checkbox"/>	Other please specify (e.g. work experience/education placement)

Please list each diagnosed condition/s and/or health care need identified by the student's medical/health practitioner and required response or adjustment? (Relevant signs and symptoms of the condition, the severity of the condition, observable behaviours associated with the diagnosis, personalised care and support requirements, activity limitations related to the condition and critical observations/thresholds which indicate need for immediate action, administration of medication or urgent medical attention/ambulance)

Diagnosed condition	Details of relevant implications and management response

List any current medication(s) prescribed for the child. Please note that in relation to any administration of medication required at school a Medication Authority Form must also be completed and updated as required.

Name of medication	Medication information/effect/administration advice (nightly, daily etc)

List:

- any medication required to be administered at school
- any medication to be administered for an acute episode or in an emergency
- the response required if the child does not respond to initial treatment
- when to call an ambulance for assistance

Medication	Instructions for administration for an acute episode in response to specific symptoms
Medication	Instructions for Emergency Administration

Please provide any further relevant information to assist the school in supporting the needs of the student at school:

This Medical Management Plan has been developed with my knowledge and input

Name of treating health practitioner/ Hospital URL : _____

AHPRA Registration number: _____

Medical /Health practitioner contact details: _____

Signature: _____ Date: _____

Name of parent/carer or adult/mature minor** student: _____

Signature: _____ Date: _____

***Please note: Mature minor is a student who is capable of making their own decisions on a range of issues, before they reach eighteen years of age.*

Name of principal (or nominee): _____

Signature: _____ Date: _____

Privacy Statement

The school collects personal information so as the school can plan and support the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information may be disclosed to relevant school staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by another law.