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| Lake Macquarie Family Day CareA Quality Education and Care Option for Our Community Ph: 02 4921 0156Email: familydaycare@lakemac.nsw.gov.au  | LMCC CMYK |
| **CHRONIC ILLNESS MANAGEMENT PLAN** |
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| **Form to be updated on a regular basis, or when a change in condition occurs.** |
|  |
| Child’s name: |  |

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| Please attach child’s photo |

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|  |  |
| Date of birth: |  |
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| Known medical condition / severe allergies |
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| **PARENT DETAIL:** | **PARENT 1** |  |
| I consent to this form being on display in the education and care service |  |
|  |  | (Full Signature) |
| Name: |  | Work phone:  |  |
|  |
| Home phone: |  | Mobile phone: |  |
|  | **PARENT 2** |  |
| Name: |  | Work phone: |  |
|  |
| Home phone: |  | Mobile phone: |  |
|  |
| **PLAN PREPARED BY** |
|  |
| Doctors name: |  | Phone: |  |
|  |  |  |  |
| Signature: |  | Address: |  |
| **USUAL MEDICATION & TREATMENT DETAILS**(when child’s condition is controlled) |
| **Name of medication/treatment** | **Dose** | **Timing** |
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| **Is any of this medication/treatment able to be self-administered by the child?** |
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| **PLEASE ADVISE SITUATIONS LIKELY TO CAUSE THE CHILD’S HEALTH TO DETERIORATE** |
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| **SIGNS/SYMPTOMS INDICATING DETERIORATING HEALTH** |
| Mild/Moderate |
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| Severe: |
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| **ACTION REQUIRED IF THESE SIGNS/SYMPTOMS OCCUR**(please include any increase of medication dose or additional medication required) |
| Mild/Moderate |
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|  |
| Severe: |
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| --- | --- |
| Date: |  |

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| ‘The information is being collected in compliance with the principles of the Privacy and Personal Information Protection Act 1998 and accordingly will only be used for the purpose for which it is being collected in emergencies or as otherwise required or authorised by law’. |