

Individual first aid plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the HEALTH PROFESSIONAL and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a child/student/client who requires individual first aid assistance.

Standard first aid plans (for a range of conditions) can be found at [A – Z Health Support Index](#) on the *chess* website www.chess.sa.edu.au. 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 (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

The child/student/client has a medical condition described as _____

And will require the following first aid response when these symptoms/reactions are observed.

Observable sign/reaction	First aid response
<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>
<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>
<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p style="text-align: center;">▽</p>
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This plan has been developed for the following services/settings: *

- | | |
|--|--|
| <input type="checkbox"/> School/education | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care | <input type="checkbox"/> Work |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> 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)