This form is developed in partnership and has co-ownership with the South Australian Department for Education and the Department for Health and Wellbeing, Women's and Children's Health Network

Government of South Australia

Individual first aid plan

for education and care

CONFIDENTIAL

HSP124

To be completed by the treating medical professional and parent or legal guardian for a child or young person who requires individual first aid assistance that is not the standard first aid response.

This information is confidential and will be available only to relevant staff and emergency medical personnel.

Name of child/young person:

DOB: Review date:

Allergies:

Education or care service:

The child or young person has a medical condition described as

The individual first aid plan is prepared in the event of

And will required the following first aid response when the follow observations are observed:

OBSERVABLE SIGN	FIRST AID RESPONSE

INDIVIDUAL FIRST AID PLAN

Health Support Planning

Government of South Australia

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INDIVIDUAL FIRST AID PLAN

Health Support Planning

AUTHORISATION AND AGREEMENT *(To be signed after form has been completed)*		The following settings have been considered in the development of the individual first aid plan and is appropriate for use in the following:	
☐	Children's centre, preschool or school	☐	Childcare, Out of School Hours Care
☐	Camps, excursions, special event, transport (incl. aquatics)	☐	Work experience or other education placement
☐	Respite, accommodation	☐	Work
☐	Transport	☐	Other (specify)

Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	
Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	
Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	
Treating health professional		
(print name & practice/hospital or stamp)	Professional role	
	Provider number	
	Email or signature	
Telephone	Date	

Parent or legal guardian; or adult student	
• **I understand and agree with the individual first aid plan as indicated above** • **I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).** • **I understand staff may seek additional information and/or advice regarding the medical information contained in the individual first aid plan from the Access Assistant Program (AAP) to inform duty of care.**	
(name)	(relationship)
(email or signature)	(date)