Outside School Hours Care
CHANGE OF MEDICAL DETAILS

	Child One	Child Two	Child Three
Child's Full Name:			
Child's Date of Birth:			
Current Year Level			

Has your child been diagnosed with diabetes, asthma or anaphylaxis?	Asthma ☐ Diabetes ☐ Anaphylaxis ☐ Please complete an EMERGENCY ACTION PLAN FOR THE ABOVE	Asthma ☐ Diabetes ☐ Anaphylaxis ☐ Please complete an EMERGENCY ACTION PLAN FOR THE ABOVE	Asthma ☐ Diabetes ☐ Anaphylaxis ☐ Please complete an EMERGENCY ACTION PLAN FOR THE ABOVE
Will you child be self-administering his/her medication?	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN

For the safety and wellbeing of all children and staff, it is mandatory for any child who has been prescribed an adrenaline auto-injection device or Diabetes testing kit and hypo pack to attend the Outside School Hours Care program with the required equipment at all times.

Other Conditions:	Does your child suffer from food intolerances, eczema, febrile convulsions or any other conditions?		
	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN
Diagnosed Disability: (Speech, Occupational therapy, Hearing, Vision etc.)	Does your child have any difficulties or disability that requires additional assistance?		
	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN
Is your child on any regular medication?	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN	☐ No ☐ Yes Please complete a HEALTH CARE PLAN
Please list any other accidents or illnesses we may need to know about:			

I GIVE CONSENT FOR STAFF TO APPLY THE FOLLOWING WHEN NECESSARY:

	CHILD ONE	CHILD TWO	CHILD THREE
Sunscreen	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Insect repellent	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Adhesive bandaids or Sticking Plaster	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DECLARATION:

I have read, understood, and agree to abide by the conditions of services **First Aid, Health Care Plans and Immunisation** procedure.
I certify that the information contained in this BOOKING ALTERATION form is correct and agree to notify the person in charge of the Service of any change to any information contained therein.

Name of Parent/Guardian (a): PLEASE PRINT	_____	Signature:	Date: / /
Name of Parent/Guardian (b): PLEASE PRINT	_____	Signature:	Date: / /
Name of Director/ Authorised Manager: PLEASE PRINT	_____	Signature:	Date: / /