Health Support Agreement

for education and care



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| To be developed by the education or care service in consultation with the parent or legal guardian, to identify and document individualised risk minimisation strategies, management and treatment for a child or young person with health or personal care needs to support inclusion and participation in the full curriculum at the site.  Must be accompanied by a Safety and Risk Management Plan.  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: |  | | |  |

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| **AUTHORISATION AND AGREEMENT**  *(To be signed after form has been completed)* | | The following settings have been considered in the development of the Health Support Agreement 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) | |
| *Education or Care staff member completing Health Support Agreement* | | | | | | | |
| (name) | | | (email or signature) | | | | (date) |
| *Principal, Director or Leader* | | | | | | | |
| (name) | | | (email or signature) | | | | (date) |
| *Parent or legal guardian; or adult student* | | | | | | | |
| I have participated in the development of, and understand, the Health Support Agreement & Safety and Risk Management Plan  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 Health Support Agreement from the Access Assistant Program (AAP) to inform duty of care. | | | | | | | |
| (name) | | | | | (relationship) | | |
| (email or signature) | | | | | (date) | | |

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| **HEALTH SUPPORT AGREEMENT REVIEW**  *This section may be completed where the agreement has been reviewed but there are no significant changes*  A Health Support Agreement, and Safety and Risk Management Plan, should be reviewed and updated in consultation with the parent or legal guardian in each of the following circumstances:   * Annually (at the start of each year) * When the care plan, action plan or health care plan has been reviewed and updated * As soon as practical after a medical emergency or incident at the children’s centre, preschool or school * Prior to the child or young person participating in an off-site activity or onsite special event | | | | |
| Date of review | Reason for review | Site representative  *(print name and initial)* | Parent or Carer  *(print name and initial)* | New Review Date  *(change at top of form)* |
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| **CARE NEEDS**  *(Identify the child or young person’s care needs that have been considered in development of Health Support Agreement)* | | | | | |
| **Personal Care** | | **Physical Health** | | **Neurodiversity** | |
|  | Oral Eating and Drinking |  | Asthma |  | Anxiety |
|  | Transfer and Positioning |  | Anaphylaxis / Severe Allergy |  | Emotional regulation |
|  | Continence |  | Diabetes |  | Autism Spectrum |
|  | Menstrual Management |  | Seizures & Epilepsy |  | Depression |
|  | Wound and Skin Care |  | Cancer |  | ADHD |
|  | Personal Hygiene |  | Cystic Fibrosis |  | Eating disorders |
|  | Head Lice |  | Acquired Brain Injury |  | Gender Diversity |
|  |  |  | Osteogenesis Imperfecta |  | FASD / Drug |
|  | Other (specify) | | | | |

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| **CARE PLANS, ACTION PLANS, MANAGEMENT PLANS**  *(Identify any documents, completed by a treating health professional, that support and advise the Health Support Agreement)* |
| (list all care/action plans) |

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| **MEDICATION** | | |
| Is medication required to be administered in an education or care service? | **YES** | **NO** |
| If yes, a [medication agreement](https://www.education.sa.gov.au/sites/g/files/net691/f/hsp151-medication-agreement.doc) must be completed by a health professional (except if this is listed in the Asthma Care Plan, or the Anaphylaxis/Allergies Action Plan) | | |

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| **HEALTH CONDITION**  *(It is not necessary to provide a full medical history. Education and care staff only need to know information relevant to the child or young person’s attendance, learning and emotional wellbeing in education and care settings.)* |
| (provide details) |

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| **Complex needs and/or invasive health support** | | |
| Does the child / young person have complex care needs and/or require invasive health support?  *(e.g. gastrostomy, nasogastric, tracheostomy care, oxygen, catheter management, postural drainage)* | **YES** | **NO** |
| If yes, a referral to the Access Assistant Program (AAP) is required   * [*Access Assistant Program Flowchart*](https://searchadmin.learnlink.sa.edu.au/s/redirect?collection=DECD-Intranet&url=https%3A%2F%2Fmyintranet.learnlink.sa.edu.au%2Flibrary%2Fdocument-library%2Ffact-sheets%2Fchild-and-student-support%2Fhealth-and-wellbeing%2Faccess_assistant_program_flow_chart.pdf&index_url=https%3A%2F%2Fmyintranet.learnlink.sa.edu.au%2Flibrary%2Fdocument-library%2Ffact-sheets%2Fchild-and-student-support%2Fhealth-and-wellbeing%2Faccess_assistant_program_flow_chart.pdf&auth=gR57B%2FHpQvoCJKmRgTzC6g&profile=_default&rank=1&query=AAP) * [*Access Assistant Program Referral*](https://www.decd.sa.gov.au/sites/g/files/net691/f/wchn_disability_services_referral_form.doc?v=1476854756) | | |
| *Provide details of complex or invasive health support needs:* | | |
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| **First Aid** | | |
| Are there additional first aid requirements other than basic first aid response?  *(e.g. in relation to asthma or anaphylaxis; administration of prescribed intranasal midazolam for seizure management; anxiety management)* | **YES** | **NO** |
| If yes, has an [Individual first aid plan](https://myintranet.learnlink.sa.edu.au/library/document-library/form/child-and-student-support/health/individual-first-aid-plan.docx) been developed and provided? | **YES** | **NO** |
| *Provide details of individual first aid requirements:* | | |
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| **Routine supervision (for health-related safety)**  ***Health Support Planning* HEALTH SUPPORT AGREEMENT HSP120** | | |
| Are there any known recommendations for additional supervision for health related safety of the child /young person)?  *(e.g. a medication agreement for administration during times when the child/young person is in the care of staff; strategies for allergy management; diabetes monitoring; identified risk of self-harm or a diagnosed mental health disorder including anxiety or symptoms that interfere with participation; illness-related problems)* | **YES** | **NO** |
| *Provide details of supervision requirements:* | | |
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| **Personal Care** | | |
| Are there requirements for additional support with or supervision during, daily personal care tasks?  *(e.g. nose-blowing, handwashing, menstruation management, continence care, oral eating & drinking)* | **YES** | **NO** |
| *Provide details of personal care requirements:* | | |
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| **Cultural and language:** | | |
| Are there any specific cultural or language needs that need to be taken into consideration?  *(e.g. cultural diversity, language, customs, beliefs, spirituality)* | **YES** | **NO** |
| *Detail any other actions, considerations or recommendations:* | | |
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| **Other considerations:** | | |
| Are there requirements for additional support needs related to the learning and/or wellbeing of the child/young person, siblings, peers, or others involved in the care of the individual?  *(e.g. psychological wellbeing, interrupted attendance, learning in other settings, deteriorating health, grief or loss issues, palliative care)* | **YES** | **NO** |
| *Detail any other actions, considerations or recommendations:* | | |
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