CLARENCE OUTSIDE SCHOOL HOURS CARE
Supported by Clarence City Council

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2027 CHILD RISK MINIMISATION AND COMMUNICATION PLAN

Child's Name	
Child's Date of Birth	
OSHC Service/s	

THIS FORM IS VALID FOR ALL OF 2026 UNLESS THERE IS A CHANGE TO AN ASSOCIATED ACTION PLAN

First Emergency Contact Name	
Relationship to child	
Contact number	

Second Emergency Contact Name	
Relationship to child	
Contact number	

Doctor	
Contact number	

Please provide details of your child's conditions/circumstances (e.g. Asthma, Diabetes, Epilepsy, Anaphylaxis, ASD, ADHD)

Symptoms, triggers and consequences of your child's conditions/circumstances:

What can be done to minimise the risk? (Avoidance of certain foods, pets or pollen etc. Provision of regulation supports, visual aides etc.)

If your child has a food allergy, can they have other foods that list on the ingredients "may contain traces of" their allergen?

☐ YES ☐ NO

Does your child take any medication? ☐ YES ☐ NO

If yes, please list the medication, type (tablet, liquid, puffer etc), dosage and frequency even if the medication is not required to be administered at the service

Please clearly describe the steps the Service should take in case of an emergency.

Is your child receiving support from specialist services e.g. occupational therapist, speech pathologist, psychologist? If yes, please list:

Would you like a meeting with Clarence Children's Services and the OSHC educators to discuss your child's condition/circumstances or support needs? ☐ YES ☐ NO

Declaration of parent / guardian:

- I will update the Clarence Children's Services coordination unit of any changes to my child's condition and/or medication.
- I will let the service know of any change of circumstances that may affect my child's condition
- I understand that if there are no changes this form (and the Authorisation and Administration of Medication form where relevant) will be valid to the end of the school year.
- I will provide a current Action Plan from my child's doctor (Asthma, risk of Anaphylaxis, Diabetes etc) with a current photo of my child attached.
- I will provide the service with the required medication as listed in their Action Plan and ensure the medication is in date
- I authorise the service to assist my child with taking medication should they require help.
- I understand that my child cannot be in attendance without current medication.

Name of parent/guardian	
Signature of parent/guardian	
Date	

Clarence OSHC Service agrees to:

- Follow the plan detailed above unless directed otherwise by paramedics in the event of an emergency and inform parents/guardians of any incidents related to this plan
- Ensure that the required medication is accessible while the child is in care and inform parents if the child's medication is administered, needs to be replenished or is out of date.
- Ensure that all staff are aware of the child's condition and the details in this plan.
- Provide training to educators
- Minimise the identified risk factors in this plan