MEDICAL RISK MINIMISATION PLAN

CHILD'S NAME:				DOB:	
1.	Details of medical condition?				
2.	Does the child need dietary modifications? *(If yes, please comment in sections below.)*	Y/N	3.	Has a medical management plan been submitted for this condition?	Y/N
4	**RISK:** What are the issues or triggers *and/or* actual/potential situations that could lead to a medical emergency?	**STRATEGY:** What can be done to reduce these risks? What resources are needed?		**WHO:** Who needs to be included in the process? Why?	
5.	**Dietary Modification: Unsafe foods, drinks & meals:** (If applicable)				
6.	**Safe foods, drinks & meals:** (If applicable)				

All relevant staff members have been made aware of this plan and understand the risk, plan to minimise the risk and how to respond if a risk has been detected.

Responsible Person Name		Date	
Responsible Person Signature			

Parent/Guardian's Name		Date	
Parent/Guardian's Signature			

Nominated Supervisor Name		Date	
Nominated Supervisor Signature			