Wyndham Vale, Vic 3024
Mobile: 0401 258 563
info@reconnectingfamilies.au
reconnectingfamilies.au
ABN: 41 998 397 672

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MEDICAL MANAGEMENT FORM

A MEDICAL MANAGEMENT FORM IS REQUIRED TO BE COMPLETED BY THE RESIDENTIAL PARENT FOR EACH CHILD WITH A DIAGNOSED MEDICAL CONDITION PRIOR TO THE COMMENCEMENT OF SERVICE:

Please email the filled out form to Info@reconnectingfamilies.au

CONFIDENTIAL

CHILD DETAILS

Name of Child:

Address:

Date of Birth:

TREATING DOCTOR DETAILS

Name of Doctor:

Practice:

Contact Number:

Email:

MEDICAL CONDITION

Name of Condition:

Does the child take any prescribed medication? Yes No

Name of Medication:

Will the medication be required during contact time? Yes No

If yes, is the child able to self-administer the medication? Yes No

If no, does the contact parent know how to administer the medication? Yes No

Will you supply the medication and any other required items? Yes No

Do you expect this condition will impact the supervised contact time? Yes No

Does the condition impact dietary or feeding needs? Yes No

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Does the condition impact toileting needs or result in incontinence issues? Yes No

Does the condition have any behavioral impacts or indicators? Yes No

If yes, please provide information below:

What are the indicators that a child with this condition requires immediate medical assistance?

Is the contact parent able to manage the medical condition? Yes No

MEDICAL CONDITION

Overview of Medical Condition:

Instructions for administration of medication:

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Impact for attendance at supervised contact:

Parent Name:

Signature of Parent:

Date: