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 return this form by email to applications@familycontactservice.com.au

FAMILY CONTACT SERVICE

PO BOX 6646
Point Cook VIC 3030

Mobile: 0459363172
Fax: 03 83539282

Applica'ons@familycontactservice.com.au
Familycontactservice.com.au

ABN: 70 310 635 706

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 ☐

Does the condition impact toileting needs or result in incontinence issues? YES ☐ NO ☐

Does the condition have any behavioral impacts or indicators? Y ☐ 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:

Impact for attendance at supervised contact:

Parent Name:	
Signature of Parent:	
Date:	