NQS

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<th>QA2</th>
<th>2.1.1</th>
<th>Each child’s health needs are supported.</th>
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<tr>
<td></td>
<td>2.1.4</td>
<td>Steps are taken to control the spread of infectious diseases and to manage injuries and illness, in accordance with recognised guidelines.</td>
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<td>2.3.2</td>
<td>Every reasonable precaution is taken to protect children from harm and any hazard likely to cause injury.</td>
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1 National Regulations

<table>
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<th>Regs</th>
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2 EYLF

<table>
<thead>
<tr>
<th>LO3</th>
<th>Children are happy, healthy, safe and connected to others.</th>
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<tr>
<td></td>
<td>Educators promote continuity of children’s personal health and hygiene by sharing ownership of routines and schedules with children, families and the community</td>
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<td>Educators discuss health and safety issues with children and involve them in developing guidelines to keep the environment safe for all</td>
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3 Aim

The service and all educators can effectively respond to and manage medical conditions including asthma, diabetes and anaphylaxis at the service to ensure the safety and wellbeing of children, educators and visitors.

The Kids’ Uni Policies and Procedures apply to Kids’ Uni North, Kids’ Uni South, South Coast Workers Child Care Centre, Kids Uni iC – Preschool, After School Care and Vacation Care (Kids’ Uni OOSH).

4 Related Policies

Additional Needs Policy (CHI-ADM-POL-003)
Death of a Child Policy (CHI-ADM-POL-014)
Emergency Service Contact Policy (CHI-ADM-POL-021)
Emergency Management and Evacuation Policy (CHI-ADM-POL-020)
Enrolment Policy (CHI-ADM-POL-022)
Food Nutrition and Beverage Policy (CHI-ADM-POL-027)
Health, Hygiene and Safe Food Policy (CHI-ADM-POL-030)
HIV AIDS Policy (CHI-ADM-POL-031)
Immunisation and Disease Prevention Policy (CHI-ADM-POL-033)
Infectious Diseases Policy (CHI-ADM-POL-035)
Privacy and Confidentiality Policy (CHI-ADM-POL-048)
5 Implementation

6.1 The service will involve all educators, families and children in regular discussions about medical conditions and general health and wellbeing throughout our curriculum. The service will adhere to privacy and confidentiality procedures when dealing with individual health needs.

6.2 A copy of the Medical Conditions Policy must be provided to all educators at the service. The policy must also be provided to parents of children enrolled at the service. Educators are also responsible for raising any concerns with a child’s parents about any medical condition known to the service, or any suspected medical condition that arises.

6.3 Any child enrolled at the service with anaphylaxis allergies, diagnosed asthma or required medication will not be able to attend the service without medication prescribed by their medical practitioner. Families are required to provide this information on the Enrolment Form as outlined below and are responsible for updating the service on any new medication, ceasing of medication, or any changes to their child’s prescription.

6.4 Families are required to provide information about their child’s health care needs, allergies, medical conditions and medication on the Enrolment Form and are responsible for updating the service about of these things, including any new medication, ceasing of medication, or changes to their child’s prescription.

6.5 All educators and volunteers at the service must follow a child’s Medical Management Plan in the event of an incident related to a child’s specific health care need, allergy or medical condition.

6 Information that must be provided in the Enrolment Record

7.1 The service’s Enrolment Form provides an opportunity for parents to help the service effectively meet their child’s needs relating to any medical condition.

7.2 The enrolment record will include details of any:
   i. Specific health care needs or medical conditions of the child, including asthma, diabetes, allergies, and whether the child has been diagnosed at risk of anaphylaxis.
   ii. Any Medical Management Plan provided by a child’s parents and/or registered medical practitioner. This Plan should
      a. Have supporting documentation if appropriate.
      b. Include a photo of the child.
      c. If relevant, state what triggers the allergy or medical condition.
      d. First aid needed.
      e. Contact details of the doctor who signed the plan.
      f. State when the Plan should be reviewed.

7.3 Copies of the plan should be kept with the child’s medication and also accompany them on any excursions.

7.4 Where there is a Medical Management Plan, a risk minimisation plan must be developed and informed from the child’s Medical Management Plan.
7.5 Parents are responsible for updating their child’s Medical Management Plan/providing a new Plan as necessary and will be regularly reminded by the service.

7.6 Any new information will be attached to the Enrolment Form and kept on file at the service. Educators will ensure information that is displayed about a child’s medical conditions is updated.

7 Identifying Children with Medical Conditions

8.1 Any information relating to the above medical conditions will be shared with the Nominated Supervisor, educators and any other staff member at the service. Individuals will be briefed by the Nominated Supervisor on the specific health needs of each child.

8.2 Information relating to a child’s medical conditions, including the child’s Medical Management Plan, Medical Conditions Risk Minimisation Plan, and the location of the child’s medication will be shared with all educators and displayed in the following areas of prominence to ensure all practices and procedures are followed accordingly.

i. Office - in child’s file
ii. All children’s playrooms
iii. Staff room

8.3 All educators at the service must follow a child’s Medical Management Plan in the event of an incident related to a child’s specific medical conditions requirements.

8.4 All educators at the service must be able to identify a child with medical conditions easily.

8.5 All educators and volunteers at the service must be able to locate a child’s medication easily.

8.6 We will ensure the display of information meets privacy guidelines and is not accessible to visitors or other families. We will explain to families why this is important for the safety of the child and obtain parental consent.

8 Medical Conditions Risk Minimisation Plan

9.1 Using a child’s Medical Management Plan, our service will develop a Medical Conditions Risk Minimisation Plan in consultation with a child’s parents which will ensure that:

i. Any risks are assessed and minimised.

ii. If relevant, practices and procedures for the safe handling of food, preparation, consumption and service of food for the child are developed and implemented. (note we will follow all health, hygiene and safe food policies and procedures)

iii. All parents are notified of any known allergens that pose a risk to a child and how these risks will be minimised.

iv. A child does not attend the service without medication prescribed by their medical practitioner in relation to their specific medical condition.

9.2 Our service will provide support and information to all parents and other members of our community about resources and support for managing allergies, anaphylaxis asthma and diabetes.

9.3 Our service will routinely review each child’s medication to ensure it hasn’t expired.
Medical Conditions Risk Minimisation Plan: Anaphylaxis/Allergy Management

10.1 While not common, anaphylaxis is life threatening. Anaphylaxis is a severe allergic reaction to a substance. While prior exposure to allergens is needed for the development of true anaphylaxis, severe allergic reactions can occur when no documented history exists. We are aware that allergies are very specific to the individual and it is possible to have an allergy to any foreign substance.

10.2 Anaphylaxis is usually caused by a food allergy. Foods most commonly associated with anaphylaxis include peanuts, seafood, nuts and in children eggs and cow’s milk. While developing the Medical Conditions Risk Minimisation Plan and to minimise the risk of exposure of children to foods that might trigger severe allergy or anaphylaxis in susceptible children, our service will:

i. Not allow children to trade food, utensils or food containers.

ii. Prepare food in line with a child’s medical management plan and family recommendations.

iii. Request families to label all bottles, drinks and lunchboxes etc with their child’s name.

iv. Consider whether it’s necessary to change or restrict the use of food products in craft, science experiments and cooking classes so children with allergies can participate.

v. Instruct educators on the need to prevent cross contamination.

vi. Request all parents not to send food with their children that contain highly allergenic elements even if their child does not have an allergy by, placing a sign on the door of each room and the kitchen reminding families about this.

vii. Where a child is known to have a susceptibility to severe allergy or anaphylaxis to a particular food, the service will have a “Allergy-Awareness policy” for that food e.g. an “Allergy-Aware Egg and Nut Policy” which would exclude children or other individuals visiting the service from bringing any foods or products containing nuts or nut material such as:

a. Peanuts, brazil nuts, cashew nuts, hazelnuts, almonds, pecan nuts.

b. Any other type of tree or ground nuts, peanut oil or other nut based oil or cooking product, peanut or any nut sauce, peanut butter, hazelnut spread, marzipan.

c. Any other food which contains nuts such as chocolates, sweets, lollies, nougat, ice creams, cakes, biscuits, bread, drinks, satays, pre-prepared Asian or vegetarian foods.

d. Foods with spices and seeds such as mustard, poppy, wheat and sesame seeds.

e. Cosmetics, massage oils, body lotions, shampoos and creams such as Arachis oil that contain nut material.

viii. Be aware that a child may have a number of food allergies or there may be a number of children with different food allergies, and it may not be possible to have an allergy free policy for all those foods involved. Nut allergy is the most likely to cause severe reaction and will take precedence.
ix. If appropriate, seat a child with allergies at a different table if food is being served that he/she is allergic to. This will always be done in a sensitive manner so that the child does not feel excluded. If a child is very young, the family may be asked to provide their own high chair to further minimise the risk of cross infection.

x. Hold non-allergic babies when they drink formula/milk or there is a child diagnosed at risk of anaphylaxis from a milk allergy.

xi. Instruct food preparation staff and volunteers about measures necessary to prevent cross contamination between foods during the handling, preparation and serving of food, such as careful cleaning of food preparation areas and utensils.

xii. Closely supervise all children at meal and snack times and ensure food is eaten in specified areas. To minimise risk children will not be permitted to ‘wander around’ the service with food.

xiii. Ensure meals prepared at the service do not contain ingredients such as eggs or nuts.

xiv. Consult risk minimisation plans when making food purchases and planning menus.

10.3 Allergic reactions and anaphylaxis are also commonly caused by:

i. All types of animals, insects, spiders and reptiles.

ii. All drugs and medications, especially antibiotics and vaccines.

iii. Many homeopathic, naturopathic and vitamin preparations.

iv. Many species of plants, especially those with thorns and stings.

v. Latex and rubber products.


10.4 Our service will ensure that body lotions, shampoos and creams used on allergic children are approved by their parent.

10.5 Risk minimisation practices will be carried out to ensure that the service is to the best of our ability providing an environment that will not trigger an anaphylactic reaction. These practices will be documented and reflected upon, and potential risks reduced if possible.

10.6 The service will display an Australasian Society of Clinical Immunology and Allergy inc (ASCIA) generic poster called Action Plan for Anaphylaxis in a key location at the service, for example, in the children’s room, the staff room or near the medication cabinet [link provided].

10.7 Our service will ensure that the auto-injection device kit is stored in a location that is known to all educators, other staff and including relief educators, easily accessible to adults (not locked away), inaccessible to children, and away from direct sources of heat.

10.8 Educators should be on the lookout for symptoms of an allergic reaction as they need to act rapidly if they do occur. If a child is displaying symptoms of an anaphylactic reaction our service will:

i. Call an ambulance immediately by dialling 000.

ii. Ensure the first aid trained educators/educators with approved anaphylaxis management training provides appropriate first aid which may include the
injection of an auto immune device EpiPen® in line with the steps outlined by the Australian Society of Clinical Immunology and Allergy [http://allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis](http://allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis) and CPR if the child stops breathing.

iii. Contact the parent/guardian or the person to be notified in the event of illness if the parent/guardian cannot be contacted.

### 10 Medical Conditions Risk Minimisation Plan: Asthma Management

11.1 Asthma is a chronic lung disease that inflames and narrows the airways. While developing the Medical Conditions Risk Minimisation Plan our service will implement procedures where possible to minimise the exposure of susceptible children to the common triggers which can cause an asthma attack. These triggers include:

i. dust and pollution
ii. inhaled allergens, for example mould, pollen, pet hair
iii. changes in temperature and weather, heating and air conditioning
iv. emotional changes including laughing and stress
v. activity and exercise

11.2 Risk minimisation practices will be carried out to ensure that the service is to the best of our ability providing an environment that will not trigger an asthmatic reaction. These practices will be documented and reflected upon, and potential risks reduced if possible.


11.4 An asthma attack can become life threatening if not treated properly. If a child is displaying asthma symptoms, our service will ensure first aid trained educators/educators with approved asthma management training immediately attends to the child.

11.5 If the procedures outlined in the child’s medical management plan do not alleviate the asthma symptoms, or the child does not have a medical management plan, the educator will provide appropriate first aid, which may include the steps outlined by Asthma Australia as follows:

i. Sit the child upright and stay with the child and be calm and reassuring
ii. Give 4 puffs of blue reliever puffer medication
   a. Use a spacer if there is one
   b. Shake puffer
   c. Put 1 puff into spacer
   d. Take 4 breaths from spacer
   e. Repeat until 4 puffs have been taken
   f. Shake, 1 puff, 4 breaths
iii. Wait 4 minutes, if there is no improvement, give 4 more puffs as above
iv. If there is still no improvement call emergency assistance 000
   a. Keep giving 4 puffs every 4 minutes until emergency assistance arrives
v. Contact the child’s parent or authorised contact where the parent cannot be reached.

11.6 The service will ensure that an asthma First Aid Kit is stored in a location that is known to all educators, other staff including relief educators, easily accessible to adults (not locked away), inaccessible to children, and at room temperature in dry areas. An Asthma First Aid kit should contain:
   i. Blue or grey reliever puffer.
   ii. A spacer device that is compatible with the puffer.
   iii. A face mask compatible with the spacer for use by children under 5.
   iv. 70% alcohol swabs for cleaning devices. Note puffers, spacers and face masks from the Kit must be thoroughly cleaned after each use to prevent cross contamination. To clean:
      a. Remove canister from puffer and wash device (but not canister) in warm water with kitchen detergent.
      b. Do not rinse or rub dry, allow devices to air dry.
      c. When dry, wipe the mouth piece inside and outside with a 70% alcohol swab.
      d. When completely dry, replace the canister and ensure puffer is working correctly.

11 Medical Conditions Risk Minimisation Plan: Diabetes

12.1 Diabetes is a chronic condition where the levels of glucose (sugar) in the blood are too high. Glucose levels are normally regulated by the hormone insulin.

12.2 The most common form of diabetes in children is type 1. The body’s immune system attacks the insulin producing cells so insulin can no longer be made. People with type 1 diabetes need to have insulin daily and test their blood glucose several times a day, follow a healthy eating plan and participate in regular physical activity. See [http://www.diabeteskidsandteens.com.au/whatisdiabetes.html](http://www.diabeteskidsandteens.com.au/whatisdiabetes.html) for an online presentation for children explaining how diabetes affects the body.

12.3 Type 2 diabetes is managed by regular physical activity and healthy eating. Over time type 2 diabetics may also require insulin.

12.4 While developing the Medical Conditions Risk Minimisation Plan our service will implement procedures where possible to ensure children with diabetes do not suffer any adverse effects from their condition while at the service. These include ensuring they do not suffer from hypoglycaemia (have a “hypo”) which occurs when blood sugar levels are too low. Things that can cause a “hypo” include:
   i. A delayed or missed meal, or a meal with too little carbohydrate
   ii. Extra strenuous or unplanned physical activity
   iii. Too much insulin or medication for diabetes
   iv. Vomiting
12.5 Children with Type 1 diabetes may also need to limit their intake of sweet foods. Our service will ensure information about the child’s diet including the types and amounts of appropriate foods is part of the child’s Medical Management Plan and that this is used to develop the Risk Minimisation Plan.

12.6 Staff will not be injecting children with insulin if diabetic as staff are not trained medical officers qualified to undertake this procedure. In the event of major concerns regarding insulin levels of a child then an ambulance will be called.

12.7 If a child is displaying symptoms of a “hypo” our service will:
   i. Ensure the first aid trained educator provides immediate first aid which will be outlined in the child’s medical management plan and may include giving the child some quick acting and easily consumed carbohydrate.
   ii. Call an ambulance by dialling 000 if the child does not respond to the first aid and CPR if the child stops breathing.
   iii. Contact the parent/guardian or the person to be notified in the event of illness if the parent/guardian cannot be contacted.

12 Skin Complaints

13.1 Rashes are common in children. They can be caused by many different viral infections and may not be infectious. It is important to be able to describe the rash as this may help with diagnosis.

13.2 When viewing a rash educators should also consider if the child is unwell. The rash may not affect the child’s well-being at all.

13.3 There are however, usually other signs and / or symptoms to consider in conjunction with a rash. These might include:
   i. Fever
   ii. Unusual behaviour (cranky or less active; cries more than usual; seems uncomfortable; just seems unwell)
   iii. Loss of appetite
   iv. Vomiting;
   v. Headache; stiff neck
   vi. Frequent scratching
   vii. Crusty skin / discharge from skin
   viii. Diarrhoea
   ix. Severe, persistent or prolonged cough
   x. Trouble breathing
   xi. Dark, tea coloured urine
   xii. Grey or very pale faeces

13 When observing the Rash

14.1 When observing the rash the following signs should be considered?
   i. What colour is the rash (dark red like a blood blister? Pink? Red?
14 Heat Rash
Educators are to remove outer layers of clothing from a child and allow the child to cool down. Rash should be checked again in half an hour to see if disappearing.

15 Reporting of Rashes
16.1 All rashes should be checked by other room educators to get a consensus on what it might be and whether there is cause for concern for the child’s health (and potentially that of the other children and also educators).

16.2 After doing this then the Nominated Supervisor and/or Manager should be consulted for a final decision.

16.3 All rashes should be documented on the “illness form”. Staff must regularly check the appearance of the rash and note time and any changes on the form. This is important information a doctor may need.

16.4 If concern is expressed about the rash then the child must be isolated from others until the parent can collect the child from the centre. If educators are concerned about serious symptoms in conjunction with the rash or perhaps the rash being purple, or spreading very quickly, then an ambulance must be called.

16.5 Meningitis is a dangerous disease that affects children and youth very rapidly. Hospital treatment is imperative. Meningitis can occur at any time but seems to peak around September / October each year.

16.6 If in doubt as to a child’s wellbeing with regards to a rash then always call the parent immediately.

16 Eczema
17.1 In the case where children have eczema then an initial doctor’s certificate must be produced stating this. The centre staff will then follow any treatment prescribed by the Doctor.

17.2 A child with eczema is not excluded from attending as this is a chronic condition that has to be managed.

17 Nappy Rash
18.1 Nappy rash commonly happens when a baby’s skin is exposed to wet or dirty nappies for too long. Urine is sterile (there are no germs in urine). However, germs on the baby’s skin and in the nappy can change chemicals in urine into other chemicals. These include chemicals such as ammonia, which is very irritating to skin. Leaving a wet nappy on a baby for long periods of time can make the rash worse.

18.2 Some babies get nappy rash no matter how well they are cared for. Others do not get nappy rash, even when they are not changed very often. Some babies may have very
sensitive skin and rashes on other parts of their bodies. Others may have infections, such as thrush, which make the rash worse. Some babies only get nappy rashes when they have a cold or some other viral illness.

18.3 Most cases of nappy rash can be treated successfully at home.

18.4 Educators should advise the parent if the baby's nappy rash looks severe, is hurting the baby or doesn't clear up within a few days. The baby should be taken to a doctor for a check and medical clearance in that situation.

18.5 The signs of nappy rash include:

i. Inflamed skin – the skin around the genital area and anus looks red and moist.

ii. Blistering – the skin may blister and then peel, leaving raw patches (ulcers).

iii. Spreading – the rash can spread onto the tummy and buttocks.

iv. Ulcers – small ulcers can sometimes form on healthy skin near the area of the rash.

All of this damage to the skin is very sore and the baby can be very unsettled, especially when they pass wee (urine) that comes into contact with the rash. Many babies with nappy rash do not sleep well, waking often due to pain.

18.6 Common causes of nappy rash include:

i. Sensitive skin

ii. A trigger factor or 'agent'

18.7 Sensitive skin

Babies who have rashes on other parts of their bodies, such as cradle cap or eczema (on the face or under the chin), are more likely to get nappy rash. – This tendency is often inherited – other members of the family may also have had rashes including nappy rash.

18.8 Some things can trigger nappy rash, including:

i. Ammonia – chemicals in urine may be changed into ammonia, which ‘burns’ the skin.

ii. Thrush (candida) – thrush exists in faeces (poo) normally but the levels rise sometimes without obvious causes. This can occur when a baby needs antibiotics for another infection. Thrush can make a nappy rash much redder and more painful.

iii. Chemical exposure – chemicals in nappy-soaking solutions, laundry detergents and fabric softeners can irritate the skin of very sensitive babies. Some baby wipes may cause irritation if they contain alcohol. Some scented soaps or baby lotions can also irritate the skin of some babies.

iv. Plastic pants – these may keep the baby's clothes clean and dry, but they prevent airflow. Because the clothes do not get wet, a baby may be left in a wet or dirty nappy for a long time and this keeps the baby's skin wet.

v. Friction or rubbing – rough nappies can rub and chafe at the baby's sensitive skin.

18.9 Suggestions to treat or prevent nappy rash include:

i. Change baby more frequently.
ii. Use disposable nappies, which absorb the urine quickly and leave the surface of the nappy (that is next to the skin) dry.

iii. Use only soaps made for babies and baby wipes that do not have alcohol in them. Wipes made for babies do not have alcohol but adult wipes often do. Alcohol stings badly on damaged skin.

iv. Clean baby's bottom with plain water at nappy changes. If this does not clean the skin well enough, try sorbolene cream – a simple and soothing cream.

v. Use a barrier cream, such as zinc and cod liver oil or zinc and castor oil, to keep wetness away from baby's skin.

vi. Make sure cloth nappies are changed often and, whenever possible, do not put plastic pants over them.

vii. Rinse thoroughly all washed nappies to remove traces of detergents and other chemicals. Then, if possible, dry them in a tumble drier – this makes them much softer than drying them in the sun.

viii. Don't put a nappy on baby whenever practical.

ix. Give pain relief if necessary. Rashes such as nappy rash are very painful, especially when urine gets onto them.

x. Seek medical advice.

18.10 If the baby's nappy rash doesn't improve after a few days, see a doctor. The nappy rash may be infected (for example, by thrush) or baby's skin may be very sensitive.

18.11 If the doctor suggests creams for thrush or steroid creams (such as hydrocortisone cream), follow the directions for use. Wash the skin well, put a thin layer of the cream on, then (after a couple of minutes) cover the skin and the cream with a barrier cream, such as zinc and cod liver oil. (Note: zinc creams leave stains on nappies and clothes. Many people use disposable nappies while treating nappy rash.)

18.12 Where to get help

i. A doctor

ii. Nurse-on-Call Tel. 1300 606 024 – for expert health information and advice (24 hours, 7 days)

iii. Maternal and Child Health nurse

iv. The Maternal and Child Health Line (24 hours) Tel. 13 22 29

v. The Royal Children's Hospital Tel. (03) 9345 5522

18.13 Things to remember

i. Nappy rash is commonly caused when a baby is left in a wet or dirty nappy for too long.

ii. Prevention and treatment options include more frequent nappy changes, using disposable nappies and covering the sore area with a barrier cream (such as zinc and cod liver oil or zinc and caster oil creams). Make sure that pure soaps made for babies and baby wipes that do not have alcohol in them, are used.

iii. If the nappy rash does not get better in a couple of days, or if it spreads onto the tummy, get advice and treatment from a doctor.
18 Educator Training and Qualifications
19.1 The approved provider must ensure that at least one educator attending the service:
   i. Holds a current approved first aid qualification.
   ii. Has undertaken current approved anaphylaxis management training and
   iii. Has undertaken current approved emergency asthma management training
19.2 Our staffing Arrangements Policy has more details about educator training and qualifications in this area.
19.3 Educators in our service recognise how serious anaphylaxis is and will undertake steps to minimise the possibility of occurrence. The service will maintain the following in relation to educator qualifications for anaphylaxis:
   i. All educators in all services whether or not they have a child diagnosed at risk of anaphylaxis undertakes training in the administration of the adrenaline auto-injection device and cardio-pulmonary resuscitation every 3 years.

19 Supervised Self-Administration of Medication by Children over Preschool Age
20.1 The service permits children over preschool age to self-administer medication.
20.2 Educators must supervise the child during this process. To promote consistency and ensure the welfare of all children using the service, educators will ensure each child follows all administration of medication, health and hygiene policies and procedures.
20.3 The self-administration of medication must be negotiated with, and approved by the child’s parents. This information will be detailed in the child’s Medical Management Plan and the Medical Conditions Risk Minimisation Plan if appropriate, and the location of the child’s medication for self-administration must also be noted and made available to educators.
20.4 The service will record all instances of supervised self-administration of medication as per the Administration of Medication Policy.

20 Sources
Education and Care Services National Regulations 2011
National Quality Standard
Asthma Australia
National Asthma Organisation
Australasian Society of Clinical Immunology and Allergy www.allergy.org.au
Australian Diabetes Council
Anaphylaxis Australia
www.betterhealth.vic.gov.au
Westmead Children’s Hospital – information site
Staying Healthy in Child Care 5th Edition, National Health and Medical Research Council

21 Review
The policy will be reviewed every 2 years. The review will be conducted by:
   • Management, Employees, Families and Interested Parties
## 22 Version Control Table

<table>
<thead>
<tr>
<th>Version Control</th>
<th>Date Released</th>
<th>Next Review</th>
<th>Approved By</th>
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<tr>
<td>1</td>
<td>August 2012</td>
<td>August 2013</td>
<td>Michele Fowler Manager – Kids Uni</td>
<td>Paragraph inserted re application of policies across all centres. Migrated into new QA format. This policy replaces the Skin Complaints and Rashes Policy and the Asthmatic Policy.</td>
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<tr>
<td>2</td>
<td>March 2013</td>
<td>August 2013</td>
<td>Michele Fowler Manager – Kids Uni</td>
<td>12.6 removed wording “Our service will ensure our first aid trained educator is trained in the use of the insulin injection device (syringes, pens, pumps) used by children at our service with diabetes.” And replaced with Staff will not be injecting children with insulin if diabetic as staff are not trained medical officers qualified to undertake this procedure. In the event of major concerns regarding insulin levels of a child then an ambulance will be called. Minor editorial changes made.</td>
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<td>3</td>
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<td>August 2014</td>
<td>Michele Fowler Manager – Kids Uni</td>
<td>Reviewed with no changes required</td>
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<tr>
<td>4</td>
<td>Aug 2014</td>
<td>Aug 2016</td>
<td>Michele Fowler Manager – Kids Uni</td>
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