

FORM 2 - GENERIC HEALTH CARE MANAGEMENT/EMERGENCY RESPONSE PLAN

STUDENT DETAILS

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| SCHOOL: | YEAR: | FORM: | INSERT PHOTO HERE (If required) |
| NAME: | DATE OF BIRTH: | | |
| ADDRESS: | GENDER: | | |
| FAMILY CONTACT DETAILS | TEACHER: | | |
| NAME: | MEDICAL DETAILS | | |
| ADDRESS: | DOCTOR 1: | | |
| RELATIONSHIP TO STUDENT: | DOCTOR 2: | TELEPHONE: | |
| TELEPHONE: (W) (H) (M) | MEDICAL CENTRE: < | | |
| NAME: | PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE. YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| ADDRESS: | DO YOU HAVE AMBULANCE COVER? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| RELATIONSHIP TO STUDENT | IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE. | | |
| TELEPHONE: (W) (H) (M) | STUDENT HAS A MEDICAL ALERT BRACELET/PENDANT YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES PROVIDE DETAILS: | | |

SECTION A – HEALTH CARE PLANNING – TO BE COMPLETED BY THE PARENT/CARER

HEALTH CARE CONDITION/NEED:

DAILY MANAGEMENT PLANNING (IF REQUIRED)

SECTION B – EMERGENCY RESPONSE PLAN – TO BE COMPLETED BY PARENT/CARER AND OR MEDICAL PRACTITIONER

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____
 DATE: / /

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| NAME: | SCHOOL: | DOB: |
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SECTION C – STAFF TRAINING REQUIREMENTS

IS SPECIFIC TRAINING FOR STAFF REQUIRED TO MANAGE YOUR CHILD'S CONDITION OR NEEDS? (YOU MAY LIKE TO DISCUSS WITH THE PRINCIPAL OR MEDICAL PRACTITIONER).

A. FOR DAILY MANAGEMENT? YES NO IF YES, PLEASE DESCRIBE:

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B. IN AN EMERGENCY? YES NO IF YES, PLEASE DESCRIBE:

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SECTION D – MEDICATION (IF APPLICABLE) – TO BE COMPLETED BY PARENT/CARER

| MEDICATION INFORMATION | INSTRUCTIONS | | | | | |
|---|-----------------------------------|--|-----------------------------------|--|-----------------------------------|--|
| | MEDICATION 1 | | MEDICATION 2 | | MEDICATION 3 | |
| NAME OF MEDICATION | | | | | | |
| EXPIRY DATE | | | | | | |
| DOSE/FREQUENCY – MAY BE AS PER THE PHARMACIST'S LABEL | | | | | | |
| DURATION (DATES) | FROM : TO: | | FROM : TO: | | FROM: TO: | |
| ROUTE OF ADMINISTRATION | | | | | | |
| ADMINISTRATION (TICK APPROPRIATE BOX) | BY SELF REQUIRES ASSISTANCE | <input type="checkbox"/> <input type="checkbox"/> | BY SELF REQUIRES ASSISTANCE | <input type="checkbox"/> <input type="checkbox"/> | BY SELF REQUIRES ASSISTANCE | <input type="checkbox"/> <input type="checkbox"/> |
| STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES)) | STORED AT SCHOOL | <input type="checkbox"/> | STORED AT SCHOOL | <input type="checkbox"/> | STORED AT SCHOOL | <input type="checkbox"/> |
| | KEPT AND MANAGED BY SELF | <input type="checkbox"/> | KEPT AND MANAGED BY SELF | <input type="checkbox"/> | KEPT AND MANAGED BY SELF | <input type="checkbox"/> |
| | REFRIGERATE | <input type="checkbox"/> | REFRIGERATE | <input type="checkbox"/> | REFRIGERATE | <input type="checkbox"/> |
| | KEEP OUT OF SUNLIGHT | <input type="checkbox"/> | KEEP OUT OF SUNLIGHT | <input type="checkbox"/> | KEEP OUT OF SUNLIGHT | <input type="checkbox"/> |
| | OTHER | <input type="checkbox"/> | OTHER | <input type="checkbox"/> | OTHER | <input type="checkbox"/> |

SECTION E – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, THE PARENT/CARER AND MEDICAL PRACTITIONER (IF REQUIRED).

THIS AGREEMENT AUTHORISES THE SCHOOL STAFF TO FOLLOW THE ADVICE OF THE STUDENT'S PARENT/CARER AND/OR MEDICAL PRACTITIONER AS SET OUT IN THE GENERIC HEALTH CARE MANAGEMENT AND EMERGENCY RESPONSE PLAN. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD'S HEALTH CARE REQUIREMENTS.

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| PRINCIPAL: | MEDICAL PRACTITIONER: (AT THE PRINCIPAL'S DISCRETION – SEE GUIDELINES) |
| DATE: | DATE: |
| PARENT/CARER: | REVIEW DATE: |
| DATE: | |

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| PARENT/CARER SIGNATURE: _____ | PRINCIPAL SIGNATURE: _____ |
| DATE: / / | FORM 2 PAGE 2 OF 3 |

