

# FORM 1 - STUDENT HEALTH CARE SUMMARY

## STUDENT DETAILS

SCHOOL:	YEAR:      FORM:	INSERT PHOTO HERE  (If required)
NAME:	DATE OF BIRTH:	
ADDRESS:	GENDER:	
<b>FAMILY CONTACT DETAILS</b>	TEACHER	
NAME:	<b>MEDICAL DETAILS</b>	
ADDRESS:	DOCTOR 1	
RELATIONSHIP TO STUDENT:	DOCTOR 2:	
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE:	
	MEDICARE NO:	
NAME:	HEALTH CARE CARD: YES <input type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS:	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"/>	
RELATIONSHIP TO STUDENT:	DO YOU HAVE AMBULANCE COVER? YES <input type="checkbox"/> NO <input type="checkbox"/> <b>IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.</b>	
TELEPHONE: (W) (H) (M)		

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

IN THE FOLLOWING TABLE, PLEASE LIST ANY HEALTH CARE CONDITIONS/NEEDS FOR WHICH YOUR CHILD REQUIRES SUPPORT AT SCHOOL THEN REQUEST ONE OR MORE OF THE FOLLOWING PLANS REQUIRED TO SUPPORT YOUR CHILD AT SCHOOL:

- A STANDARDISED PLAN FOR COMMON CONDITIONS** (E.G. ANAPHYLAXIS, ALLERGIES, SEIZURES, DIABETES, ASTHMA, ACTIVITIES OF DAILY LIVING SUCH AS PEG FEEDING);
- A GENERIC PLAN FOR OTHER LESS COMMON HEALTH CONDITIONS;**
- AN ADMINISTRATION OF MEDICATION PLAN:** SHOULD BE COMPLETED IF THE MEDICATION YOU REQUIRE TO BE ADMINISTERED AT SCHOOL HAS NOT BEEN INCLUDED IN A STANDARDISED OR GENERIC PLAN E.G. SHORT TERM USE OF ANTIBIOTICS; AND/OR
- A PLAN PROVIDED BY MEDICAL PRACTITIONER.**

PLEASE TICK HEALTH CARE CONDITION/S AND OR NEED/S REQUIRING SUPPORT AT SCHOOL	MEDIC ALERT	STANDARDISED PLAN COMPLETED AND ATTACHED	SPECIFIC TRAINING REQUIRED TO SUPPORT THE STUDENT
SEVERE ALLERGY ANAPHYLAXIS (FORM 4)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
MINOR & MODERATE ALLERGIES (FORM 5)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
DIABETES (FORM 6)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
SEIZURES (FORM 7)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
ASTHMA (FORM 8)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTIVITIES OF DAILY LIVING (FORM 9)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
EMERGENCY RESPONSE PLAN FOR STUDENTS WITH SPECIAL NEEDS (FORM 10)	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
OTHER CONDITION(S) OR NEED(S) (PLEASE LIST AND COMPLETE GENERIC PLAN - FORM 2)		A GENERIC PLAN COMPLETED AND ATTACHED (FORM 2)	SPECIFIC TRAINING REQUIRED TO SUPPORT THE STUDENT
	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
PLAN PROVIDED BY MEDICAL PRACTITIONER	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
SHORT TERM MEDICATION REQUIRED (FORM 3)	<input type="checkbox"/>	ADMINISTRATION OF MEDICATION (FORM 3) COMPLETED YES <input type="checkbox"/> NO <input type="checkbox"/>	

PARENT/CARER SIGNATURE: \_\_\_\_\_

PRINCIPAL SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

NAME: SCHOOL: DOB:

**SECTION B: INFORMED CONSENT**

IS THE STUDENT HEALTH CARE SUMMARY TO BE SHARED WITH ALL STAFF? YES  NO

IF NO, AND THE INFORMATION IS TO BE RESTRICTED, WHO WILL BE INFORMED? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION C: PHOTO IDENTIFICATION FOR HEALTH CARE PLAN**

PHOTO ID REQUIRED YES  NO

IF YES, PLEASE ATTACH TO RELEVANT HEALTH CARE PLAN(S) AND OR THE STUDENT HEALTH CARE SUMMARY.

**SECTION D MEDICAL ALERT INFORMATION**

STUDENT HAS A MEDICAL ALERT BRACELET/PENDANT YES  NO

IF YES PROVIDE DETAILS:

**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 THIS STUDENT HEALTH CARE SUMMARY AND SUPPORTING DOCUMENTATION. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD’S HEALTH CARE REQUIREMENTS.

PRINCIPAL:  
DATE:

MEDICAL PRACTITIONER: (AT THE PRINCIPAL’S DISCRETION – SEE GUIDLELINES)  
DATE:

PARENT/CARER:  
DATE:

REVIEW DATE:

**OFFICE USE ONLY**

HAVE SUPPLEMENTARY FORMS BEEN PROVIDED? YES  NO  DATE:

IS SPECIFIC TRAINING REQUIRED TO SUPPORT THE STUDENT? YES  NO

PRINCIPAL SIGNATURE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_