

FORM 1 Student Health Care Summary

SECTION A

Year			Form			Teacher	
Student's name							
Date of birth (dd/mm/yy)	/	/		Gender	Male	Female	Not Specified
Address							
						Postcoo	de
FAMILY CONTACT DETAILS							
Name							
Relationship to student							
Address							
						Postcoo	de
Telephone (Home)				Telephone (W	/ork)		
Telephone (Mobile)							
Name							
Relationship to student							
Address							
						Postcoo	de
Telephone (Home)				Telephone (W	/ork)		
Telephone (Mobile)							

MEDICAL DETAILS

Medical practice

Doctor 1		Telephone				
Doctor 2			Telephone			
	YES	NO				
If there is a medical emergency, parents/ca	rers are expe	ected	to meet the cost of an ambulance.			
List any essential information that could	d affect you	ır chil	Id in an emergency e.g. allergy to penicillin.			

Medicare Card number

Medicare Card Individual Reference Number (IRN)

Expiry date (dd/mm/yy)

ADMINISTRATION OF MEDICATION

Written authorisation must be provided for staff to administer any form of medication at school.

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Long term medication – Complete the *Medication section* of the relevant health care plan – see below. Short term medication – Request an *Administration of Medication form* to complete and return to the Principal or class teacher. Note: All medication required must be supplied by parents/carers.

INFORMED CONSENT

Your child's health care information will be shared with staff on a need to know basis unless otherwise stated.

Do you give permission for the school to share your child's health care information? YES NO

Note: If your child is enrolled in a TAFE, PEAC or an alternative education program, this includes the transfer of their health care information to the principal or manager of that program.

If no, and the information is to be restricted, who can be informed of your child's health care information?

Does your child have one or more health condition(s) that will require support from school staff? (Check the box that applies)

NO - Sign below and return Section A of this form to the school office. If your child's requirements change, please notify the school.

Signature

If you are completing this form online and are unable to sign this form please check this box to confirm the above information is true and correct. Note: In the event that statements made in this application later prove to be false or misleading this application may be declined. Information supplied may need to be checked by the school.

Date

YES - Complete the remainder of this form and return to the school office. You will be given additional forms to complete.

List your child's health condition(s)

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SECTION B

IN THE FOLLOWING TABLE, PLEASE INDICATE YOUR CHILD'S CONDITION(S) WHICH <u>REQUIRE THE SUPPORT OF SCHOOL STAFF</u>. (In response to the information below, you will be given further forms for specific health conditions to complete)

Health conditions (Check the box that applies)	Will school	staff require specific training to support your child?
Severe Allergy/Anaphylaxis	YES	NO
Minor and Moderate Allergies	YES	NO
Diabetes	YES	NO
Seizures	YES	NO
Asthma	YES	NO
Activities of Daily Living	YES	NO
Other Conditions or Needs (Please specify below)	YES	NO

Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition?

YES NO - If yes, advise the Principal:

If you have ticked Yes for specific staff training, please discuss the type of training needed with the Principal.

SECTION C - CONSENT FOR PHOTO IDENTIFICATION ON YOUR CHILD'S HEALTH CARE PLAN

If your child has a condition where an emergency may occur, please indicate whether you give consent for staff to place your child's medical details and photo on view to provide immediate identification.

I give	permission	n for my	child's	medica	al details	s and	photo to be on view for staff.	YES	NO

If yes, please attach photo to the relevant health care plan(s).

SECTION D - MEDIC ALERT INFORMATION

Does y	our child	have a	a Medic	Alert	bracelet	or	pendant?
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YES NO - If yes, provide details below:

Parent/Carer Signature

Date / /

Parent/Carer Name

If you are completing this form online and are unable to sign this form please check this box to confirm the above information is true and correct. Note: In the event that statements made in this application later prove to be false or misleading this application may be declined. Information supplied may need to be checked by the school.

ON COMPLETION OF THIS FORM, PLEASE REQUEST AND COMPLETE THE RELEVANT HEALTH CARE PLANS.

Note: Where appropriate students should be encouraged to participate in their health care planning.

OFFICE USE ONLY					
Does the child have an allergy that needs to be flagged on SIS?	YES	NO	Date	/	/
Have relevant health care plans been issued to the parent?	YES	NO	Date	/	/
Has the Principal been informed if:					
specific training is required to support the student?	YES	NO			
the student's health care information is to be restricted?	YES	NO			
Date Student Health Care Summary was completed and uploaded on SIS:			Date	/	/