

FORM 1 – STUDENT HEALTH CARE SUMMARY

SECTION A

School: _____ Year: _____ Form: _____ Teacher: _____
 Student's Name: _____ Date of Birth: _____
 Address: _____ Gender: _____

FAMILY CONTACT DETAIL

Name: _____
 Relationship to student: _____
 Address: _____

Telephone: (W) _____
 (H) _____
 (M) _____

Name: _____
 Relationship to student: _____
 Address: _____

Telephone: (W) _____
 (H) _____
 (M) _____

MEDICAL DETAILS

Medical Practice: _____
 Doctor 1: _____ Telephone: _____
 Doctor 2: _____ Telephone: _____
 I give permission for the school to seek medical attention for my child as required from the above medical centre. Yes No
 Do you have ambulance cover? Yes No
If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.
 List any essential information that could affect your child in an emergency e.g. allergy to penicillin. _____

Health care card: Yes No

Medicare No. (If required – for children requiring regular emergency care): _____

ADMINISTRATION OF MEDICATION INFORMATION

If at any time your child requires short term medication to be given at school, please request an *Administration of Medication* form to complete and return to your principal or class teacher. The school requires written authorisation from you to administer any form of medication

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 a health condition or need that **requires support** from school staff while he or she is in their care?
 Yes - complete the remainder of this form and return to the school office. You will be given additional forms to complete.
 No - sign and return to the school office. If your child's requirements change, please notify the school immediately.

List your child's health condition(s): _____
 Signature: _____ Date: _____

SECTION B – IN THE FOLLOWING TABLE, PLEASE INDICATE YOUR CHILD'S CONDITION WHICH REQUIRES THE SUPPORT OF SCHOOL STAFF (In response to the information below, you will be given further forms for specific health conditions to complete)

Health Conditions	Tick health condition	Will school staff require specific training to support your child?
Severe Allergy/Anaphylaxis	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Minor & Moderate Allergies	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Diabetes	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Seizures	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Asthma	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Activities Of Daily Living	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Other Conditions or Needs (Please specify)

YES NO

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 with the Principal.

Name:

Date of Birth:

School:

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 for my child's "medical details 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 your child have a Medic Alert bracelet or pendant? Yes No

If yes, provide details: _____

Signature:

Parent/Carer Signature: _____ Date: _____

Parent/Care Name: _____

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 a 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: / /