

# FORM 1 – STUDENT HEALTH CARE SUMMARY

## SECTION A

School:	Year:	Form:	Teacher:
Student's Name:	Date of Birth:		
Address:	Gender: Male/Female		

FAMILY CONTACT DETAIL	MEDICAL DETAILS
Name:	Medical Practice:
Relationship to student:	Doctor 1: Telephone:
	Doctor 2: Telephone:
	Dental Practice:
	Name of Dentist: Telephone:
Address:	I give permission for the school to seek medical/dental attention for my child as required. Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone: (W) (H) (M)	Do you have ambulance insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Insurance Provider: If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.
Name:	List any essential information that could affect your child in an emergency e.g. allergy to penicillin.
Relationship to student:	
Address:	Health care card: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiry Date Card Number
Telephone: (W) (H) (M)	Medicare No. (If required – for children requiring regular emergency care): Card Number: Expiry Date:

## ADMINISTRATION OF MEDICATION

Written authorisation must be provided for staff to administer any form of medication at school.  
**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?  
 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: \_\_\_\_\_ 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): \_\_\_\_\_

## SECTION B – IN THE FOLLOWING TABLE, PLEASE INDICATE YOUR CHILD'S CONDITION(S) WHICH REQUIRE 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)

	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition?		YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes, advise the Principal		

If you have ticked "Yes" for specific staff training, please discuss the type of training needed 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/Carer 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 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:    /    /