



# FORM 1

## STUDENT HEALTH CARE SUMMARY

### SECTION A

|                                 |             |                                         |
|---------------------------------|-------------|-----------------------------------------|
| <b>Year</b>                     | <b>Form</b> | <b>Teacher</b>                          |
| <b>Student's name</b>           |             |                                         |
| <b>Date of birth</b> (dd/mm/yy) | / /         | <b>Gender</b> Male Female Not Specified |
| <b>Address</b>                  |             |                                         |
| Postcode                        |             |                                         |

### FAMILY CONTACT DETAILS

|                                |                         |
|--------------------------------|-------------------------|
| <b>Name</b>                    |                         |
| <b>Relationship to student</b> |                         |
| <b>Address</b>                 |                         |
|                                | Postcode                |
| <b>Telephone (Home)</b>        | <b>Telephone (Work)</b> |
| <b>Telephone (Mobile)</b>      |                         |
| <b>Name</b>                    |                         |
| <b>Relationship to student</b> |                         |
| <b>Address</b>                 |                         |
|                                | Postcode                |
| <b>Telephone (Home)</b>        | <b>Telephone (Work)</b> |
| <b>Telephone (Mobile)</b>      |                         |

## MEDICAL DETAILS

### Medical practice

Doctor 1

Telephone

Doctor 2

Telephone

**Do you have ambulance insurance?** YES NO - If yes, specify insurance provider:

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.

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.

**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

Date / /

**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.

**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 (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 |
| <b>Other Conditions or Needs</b> (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 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 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

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