FORM 1 – STUDENT HEALTH CARE SUMMARY

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PLEASE RETURN THIS FORM TO ADMINISTRATION OFFICE

SECTION A

Students Full Name:		**Year:** *	
Address:		**Postcode:**	
Date of Birth:	**Gender:** ☐ Male ☐ Female ☐ Other		

FAMILY CONTACT DETAILS

Parent/Caregiver 1:		**Relationship To Student:**	
Address:		**Postcode:**	
Mobile Number:		**Telephone Work:**	
Parent/Caregiver 2:		**Relationship To Student:**	
Address:		**Postcode:**	
Mobile Number:		**Telephone Work:**	

MEDICAL DETAILS

Medical Practice:	**Telephone:**

Permission to Administer First Aid	Permission to Call Doctor	Do you have Ambulance Cover?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

If there is a medical emergency, parents / caregivers are expected to meet the cost of an ambulance.

If ***YES to Ambulance Cover,*** *please specify* your **Insurance Provider:**	**Provider:**

List below any essential information that could affect your child in an emergency ***e.g. Allergy to Penicillin***

Medicare Card Number:	**Ref No.**	**Expiry Date:**

ADMINISTRATION OF MEDICATION

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

Long Term Medication – Complete the medication section of the relevant Health Care Plan/s – see below

Short-Term Medication – Request an **Administration of Medication** form to complete and **return to the Administration office with medication. Note:**
ALL medication required, must be supplied by parents / caregivers.

INFORMED CONSENT

Your child's health care information will be shared with staff on a need-to-know basis where a medical emergency may occur, unless otherwise stated.

*If your child is enrolled in **PEAC** or an **alternative education program,** this includes the transfer of their health care information. to the Manager or Principal of that program.*

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

*If **NO,*** and the information is to be restricted, who can be informed 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 / training from school staff? ***(Check the box that applies)***

If you answered ***NO*****,** please sign below for **Section A**. ***If your child's requirements change, please notify the school.***

Parent / Caregiver: _____ (Signature for Section A only)	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.**

If you answered ***YES,*** - please continue to **Section B, C, & D**.

SECTION B – HEALTH CONDITIONS

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
☐ Asthma	☐ YES ☐ NO
☐ Seizures	☐ YES ☐ NO
☐ Activities Daily Living	☐ YES ☐ NO
☐ **Other Conditions** or **Needs** *(please specify below)*	☐ YES ☐ NO

Other Conditions *(please specify)*

Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition?	☐ YES ☐ NO

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

SECTION D – MEDICAL ALERT INFORMATION

Does your child have a Medic Alert bracelet or pendant?	☐ YES ☐ NO

If ***YES,*** please provide details

PARENT / CAREGIVER NAME

Parent / Caregiver Full Name:

Parent / Caregiver: _____ (Signature for Sections A, B, C, D)	**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.**

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 - Student ***Health Care Summary was completed and uploaded on SIS***

Signature:	**Date:**

Submit