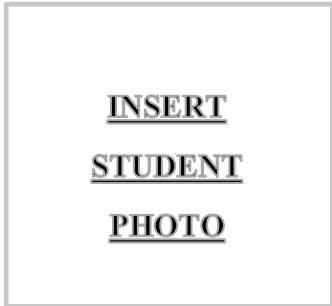




FORM 10 - EMERGENCY RESPONSE PLAN FOR A STUDENT WITH SPECIAL NEEDS

60 Kelvin Street, Maylands 6051
Phone: (08) 9462 6700
Email: maylandspeninsula.ps@education.wa.edu.au

THIS FORM IS TO BE USED FOR SPECIFYING THE EMERGENCY ACTION PLAN REQUIRED FOR SPECIAL NEEDS STUDENTS WITH MULTIPLE CONDITIONS.



PLEASE RETURN THIS FORM TO ADMINISTRATION OFFICE

Student Name: _____

Year: _____	Form: _____	Teacher: _____
DOB: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	

DETAILS

Parent Caregiver Name: _____

Relationship to student: _____	Mobile: _____	
Medical Practitioner: _____	Medical Practice: _____	
Telephone: _____		
Specialist Centre/Hospital: _____	Telephone: _____	
Specialist Address: _____		
Medicare Card Number: _____	Ref No. _____	Expiry Date: _____
Health Care Card: Yes <input type="checkbox"/> No <input type="checkbox"/>	Health Care Card No: _____	

Section A – Health Conditions/Needs: Diagnosis/s: List Below

	Medic Alert		Medic Alert		Medic Alert
	YES <input type="checkbox"/>		YES <input type="checkbox"/>		YES <input type="checkbox"/>
	NO <input type="checkbox"/>		NO <input type="checkbox"/>		NO <input type="checkbox"/>
	YES <input type="checkbox"/>		YES <input type="checkbox"/>		YES <input type="checkbox"/>
	NO <input type="checkbox"/>		NO <input type="checkbox"/>		NO <input type="checkbox"/>
	YES <input type="checkbox"/>		YES <input type="checkbox"/>		YES <input type="checkbox"/>
	NO <input type="checkbox"/>		NO <input type="checkbox"/>		NO <input type="checkbox"/>

SECTION B – DAILY HEALTH CARE ROUTINES

Routine	Required	Comments
Communication	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Diet or feeding	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Toileting	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Transportation	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Classroom Activities	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Behaviour	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Other	YES <input type="checkbox"/> NO <input type="checkbox"/>	

SECTION C- MEDICAL HISTORY

SECTION D – MEDICATION RECORDS - TO BE COMPLETED IN COLLABORATION WITH THE PRINCIPAL AND PARENT / CAREGIVER

Medication e.g., Insulin	Expiry Date	Dose/ Frequency	Route of Administration	Name of Administrator	Storage Place
					Stored at school <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/>
					Stored at school <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/>
					Stored at school <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/>

SECTION E: EMERGENCY ACTION PLAN /S

(Please list for each relevant diagnosis and attach relevant plan/s)

SECTION F – EQUIPMENT

Mobility:

--

Health Care Supplies:

Assisted Technology: e.g. Walker, Wheelchair, Communication Device, Oxygen Tank

Other Relevant Information:



**FORM 12 – RECORD OF HEALTH CARE SUPPORT
ADMINISTRATION OF MEDICATION**

60 Kelvin Street, Maylands 6051
Phone: (08) 9462 6700
Email: maylandspeninsula.ps@education.wa.edu.au

Student:

Year: **Form:** **Teacher:**

DOB: **Gender:** **Male** **Female** **Other**

RECORD OF HEALTH CARE SUPPORT / ADMINISTRATION OF MEDICATION

DATE	TIME	MEDICATION	DOSAGE	STAFF MEMBERS NAMES	SIGN / INITIALS