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.

INSERT STUDENT PHOTO

PLEASE RETURN THIS FORM TO ADMINISTRATION OFFICE

Student Name:		
Year: *	**Form:**	**Teacher:**
DOB:	**Gender:** ☐ Male ☐ Female ☐ 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 ☐ No ☐	**Health Care Card No:**	

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

	Medic Alert		Medic Alert		Medic Alert
	YES ☐ NO ☐		YES ☐ NO ☐		YES ☐ NO ☐
	YES ☐ NO ☐		YES ☐ NO ☐		YES ☐ NO ☐
	YES ☐ NO ☐		YES ☐ NO ☐		YES ☐ NO ☐

SECTION B – DAILY HEALTH CARE ROUTINES

Routine	Required	Comments
Communication	YES ☐ NO ☐	
Diet or feeding	YES ☐ NO ☐	
Toileting	YES ☐ NO ☐	
Transportation	YES ☐ NO ☐	
Classroom Activities	YES ☐ NO ☐	
Behaviour	YES ☐ NO ☐	
Other	YES ☐ NO ☐	

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 Refrigerate Keep out of sunlight	☐ ☐ ☐
					Stored at school Refrigerate Keep out of sunlight	☐ ☐ ☐
					Stored at school Refrigerate Keep out of sunlight	☐ ☐ ☐

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:

Submit

Maylands Peninsula
PRIMARY SCHOOL
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FORM 12 – RECORD OF HEALTH CARE SUPPORT ADMINISTRATION OF MEDICATION

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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	