FORM 2 – GENERIC HEALTH CARE MANAGEMENT & EMERGENCY REPSONSE PLAN

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

PLEASE RETURN THIS FORM TO ADMINISTRATION OFFICE

Student Name:

DOB: | **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**

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

SECTION A – HEALTH CARE PLANNING – TO BE COMPLETED BY THE PARENT/CAREGIVER:

DAILY MANAGEMENT PLANNING (IF REQUIRED):

SECTION B – EMERGENCY RESPONSE PLAN (IF REQUIRED) – TO BE COMPLETED BY PARENT/CARER AND / OR MEDICAL PRACTITIONER.

SECTION C – STAFF TRAINING REQUIRMENTS

Is specific training for staff required to manage your child's condition or needs?
(You may like to discuss with the principal or a medical practitioner).

A. For Daily Management? Yes ☐ No ☐	**If YES', please describe:**
B. In an emergency? Yes ☐ No ☐	**If 'YES', please describe:**

SECTION D - MEDICATION INSTRUCTIONS - *(NOTE - MEDICATION MUST BE PROVIDED BY PARENTS / CAREGIVER)*

	MEDICATION 1	MEDICATION 2	MEDICATION 3
Name of Medication			
Expiry Date			
Dose / frequency *(As per pharmacist's label)*			
Duration Dates	From:	From:	From:
	To:	To:	To:
Route of Administration			
Administration *Tick appropriate box*	By self ☐ Requires assistance ☐	By self ☐ Requires assistance ☐	By self ☐ Requires assistance ☐
Storage instructions *Tick appropriate box(es)*	Stored at school ☐ Kept and managed by self ☐ Refrigerate ☐ Keep out of sunlight ☐ Other ☐	Stored at school ☐ Kept and managed by self ☐ Refrigerate ☐ Keep out of sunlight ☐ Other ☐	Stored at school ☐ Kept and managed by self ☐ Refrigerate ☐ Keep out of sunlight ☐ Other ☐

SECTION E – AUTHORITY TO ACT	
This plan and emergency response plan authorises school staff school staff to provide health care support for my/our child in accordance with the above plan and/or the attached plan from a medical practitioner. **It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.**	
Parent/Caregiver Signature:	**Date:**
Medical Practitioner Signature: ***(If required at the principal's discretion)***	**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.**	

OFFICE USE ONLY	
Date received:	**Date uploaded on SIS:**
Is specific staff training required? Yes ☐ No ☐	
Type of training:	**Training service provider:**
Name of person/s to be trained:	
Date of training:	

FORM 12 – RECORD OF HEALTH CARE SUPPORT ADMINISTRATION OF MEDICATION

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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	