



# 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

**Name**

**Relationship to student**

**Address**

Postcode

**Telephone (Home)** **Telephone (Work)**

**Telephone (Mobile)**

**Name**

**Relationship to student**

**Address**

Postcode

**Telephone (Home)** **Telephone (Work)**

**Telephone (Mobile)**

## 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)

<b>Health conditions</b> (Check the box that applies)	<b>Will school staff require specific training to support your child?</b>	
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

**Does the child have an allergy that needs to be flagged on SIS?**      YES      NO      **Date**      /      /

**Have relevant health care plans been issued to the parent?**      YES      NO      **Date**      /      /

**Has the Principal been informed if:**

specific training is required to support the student?      YES      NO

the student's health care information is to be restricted?      YES      NO

**Date** *Student Health Care Summary* was completed and uploaded on SIS:      **Date**      /      /