



# 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

<b>Name</b>	
<b>Relationship to student</b>	
<b>Address</b>	
Postcode	
<b>Telephone (Home)</b>	<b>Telephone (Work)</b>
<b>Telephone (Mobile)</b>	
<b>Name</b>	
<b>Relationship to student</b>	
<b>Address</b>	
Postcode	
<b>Telephone (Home)</b>	<b>Telephone (Work)</b>
<b>Telephone (Mobile)</b>	

## 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)

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
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**      /      /