FORM 2 - GENERIC HEALTH CARE MANAGEMENT/EMERGENCY RESPONSE

STUDENT DETAILS

SCHOOL:	YEAR: FORM:	INSERT PHOTO HERE (If required)
NAME:	DATE OF BIRTH:	
ADDRESS:	GENDER:	
FAMILY CONTACT DETAILS	TEACHER:	
NAME:	**MEDICAL DETAILS**	
ADDRESS:	DOCTOR 1:	
RELATIONSHIP TO STUDENT:	DOCTOR 2:	TELEPHONE:
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE:	
NAME:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE. YES ☐ NO ☐	
ADDRESS:		
RELATIONSHIP TO STUDENT:	DO YOU HAVE AMBULANCE COVER? YES ☐ NO ☐ IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.	
TELEPHONE: (W) (H) (M)	**STUDENT HAS A MEDICALERT BRACELET/PENDANT** YES ☐ NO ☐ IF YES PROVIDE DETAILS:	

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

HEALTH CARE CONDITION/NEED:

DAILY MANAGEMENT PLANNING (IF REQUIRED)

SECTION B – EMERGENCY RESPONSE PLAN – TO BE COMPLETED BY PARENT/CARER AND OR MEDICAL PRACTITIONER

PARENT/CARER SIGNATURE: _____PRINCIPAL SIGNATURE:_____
DATE: / /

NAME:	SCHOOL:	DOB:

SECTION C – STAFF TRAINING REQUIREMENTS

IS SPECIFIC TRAINING FOR STAFF REQUIRED TO MANAGE YOUR CHILD'S CONDITION OR NEEDS? (YOU MAY LIKE TO DISCUSS WITH THE PRINCIPAL OR 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 (IF APPLICABLE) – TO BE COMPLETED BY PARENT/CARER

MEDICATION INFORMATION	INSTRUCTIONS		
	MEDICATION 1	MEDICATION 2	MEDICATION 3
NAME OF MEDICATION			
EXPIRY DATE			
DOSE/FREQUENCY – MAY BE AS PER THE PHARMACIST'S LABEL			
DURATION (DATES)	FROM : TO:	FROM : TO:	FROM: 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 – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, THE PARENT/CARER AND MEDICAL PRACTITIONER (IF REQUIRED).

THIS AGREEMENT AUTHORISES THE SCHOOL STAFF TO FOLLOW THE ADVICE OF THE STUDENT'S PARENT/CARER AND/OR MEDICAL PRACTITIONER AS SET OUT IN THE GENERIC HEALTH CARE MANAGEMENT AND EMERGENCY RESPONSE PLAN. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD'S HEALTH CARE REQUIREMENTS.

PRINCIPAL: **DATE:**	**MEDICAL PRACTITIONER: (AT THE PRINCIPAL'S DISCRETION – SEE GUIDELINES)** **DATE:**
PARENT/CARER: **DATE:**	**REVIEW DATE:**

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME:	SCHOOL:	DOB:
OFFICE USE ONLY		
IS SPECIFIC STAFF TRAINING REQUIRED? **YES** ☐ **NO** ☐		DATE:
TYPE OF TRAINING:		
NAME OF PERSONS TO BE TRAINED:		
PRINCIPAL SIGNATURE:		
COMPLETE ONLY RELEVANT SECTIONS AND ATTACH THE STUDENT HEALTH CARE SUMMARY FORM TO THE FRONT OF THIS DOCUMENT.		FORM 2 PAGE 3 OF 3