CARNARVON SCHOOL OF THE AIR

FORM 1 - STUDENT HEALTH CARE SUMMARY

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:	MEDICARE NO:	
	HEALTH CARE CARD: YES ☐ NO ☐	
ADDRESS:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE YES ☐ NO ☐	
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)		

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

IN THE FOLLOWING TABLE, PLEASE LIST ANY HEALTH CARE CONDITIONS/NEEDS FOR WHICH YOUR CHILD REQUIRES SUPPORT AT SCHOOL THEN REQUEST ONE OR MORE OF THE FOLLOWING PLANS REQUIRED TO SUPPORT YOUR CHILD AT SCHOOL:

- **A STANDARDISED PLAN FOR COMMON CONDITIONS** (E.G. ANAPHYLAXIS, ALLERGIES, SEIZURES, DIABETES, ASTHMA, ACTIVITIES OF DAILY LIVING SUCH AS PEG FEEDING);
- **A GENERIC PLAN FOR OTHER LESS COMMON HEALTH CONDITIONS;**
- **AN ADMINISTRATION OF MEDICATION PLAN**: SHOULD BE COMPLETED IF THE MEDICATION YOU REQUIRE TO BE ADMINISTERED AT SCHOOL HAS NOT BEEN INCLUDED IN A STANDARDISED OR GENERIC PLAN E.G. SHORT TERM USE OF ANTIBIOTICS; AND/OR
- **A PLAN PROVIDED BY MEDICAL PRACTITIONER.**

PLEASE TICK HEALTH CARE CONDITION/S AND OR NEED/S REQUIRING SUPPORT AT SCHOOL		MEDIC ALERT	**STANDARDISED PLAN COMPLETED AND ATTACHED**	**SPECIFIC TRAINING REQUIRED TO SUPPORT THE STUDENT**
SEVERE ALLERGY ANAPHYLAXIS (FORM 4)	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
MINOR & MODERATE ALLERGIES (FORM 5)	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
DIABETES (FORM 6)	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
SEIZURES (FORM 7)	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
ASTHMA (FORM 8)	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
ACTIVITIES OF DAILY LIVING (FORM 9)	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
EMERGENCY RESPONSE PLAN FOR STUDENTS WITH SPECIAL NEEDS (FORM 10)	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
OTHER CONDITION(S) OR NEED(S) (PLEASE LIST AND COMPLETE GENERIC PLAN - FORM 2)			**A GENERIC PLAN COMPLETED AND ATTACHED (FORM 2)**	**SPECIFIC TRAINING REQUIRED TO SUPPORT THE STUDENT**
	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
PLAN PROVIDED BY MEDICAL PRACTITIONER	☐	☐	**YES ☐ NO ☐**	**YES ☐ NO ☐**
SHORT TERM MEDICATION REQUIRED (FORM 3)	☐		**ADMINISTRATION OF MEDICATION (FORM 3) COMPLETED YES ☐ NO ☐**	

PARENT/CARER SIGNATURE:_____ PRINCIPAL SIGNATURE:_____

DATE:

NAME: SCHOOL: DOB:

SECTION B: INFORMED CONSENT

IS THE STUDENT HEALTH CARE SUMMARY TO BE SHARED WITH ALL STAFF? YES ☐ NO ☐

IF NO, AND THE INFORMATION IS TO BE RESTRICTED, WHO WILL BE INFORMED? _____

_____

_____

_____

SECTION C: PHOTO IDENTIFICATION FOR HEALTH CARE PLAN

PHOTO ID REQUIRED YES ☐ NO ☐
IF YES, PLEASE ATTACH TO RELEVANT HEALTH CARE PLAN(S) AND OR THE STUDENT HEALTH CARE SUMMARY.

SECTION D MEDICALERT INFORMATION

STUDENT HAS A MEDICALERT BRACELET/PENDANT YES ☐ NO ☐
IF YES PROVIDE DETAILS:

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 THIS STUDENT HEALTH CARE SUMMARY AND SUPPORTING DOCUMENTATION. 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 GUIDLELINES)** **DATE:**
PARENT/CARER: **DATE:**	**REVIEW DATE**:

OFFICE USE ONLY

HAVE SUPPLEMENTARY FORMS BEEN PROVIDED? **YES** ☐ **NO** ☐ DATE:
IS SPECIFIC TRAINING REQUIRED TO SUPPORT THE STUDENT? **YES** ☐ **NO**

PRINCIPAL SIGNATURE: