FORM 1 – STUDENT HEALTH CARE SUMMARY

SECTION A

School: **JOONDALUP EDUCATION SUPPORT CENTRE** Year: Form: Teacher:
Student's Name: Date of Birth:
Address: Gender:

FAMILY CONTACT DETAIL

Name:

Relationship to student:

Address:

Telephone: (W)
(H)
(M)

Name:

Relationship to student:

Address:

Telephone: (W)
(H)
(M)

MEDICAL DETAILS

Medical Practice:
Doctor 1: Telephone:
Doctor 2: Telephone:

I give permission for the school to seek medical attention for my child as required from the above medical centre. **Yes ☐ No ☐**

Do you have ambulance cover? **Yes ☐ No ☐**

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.

_____

Health care card: **Yes ☐ No ☐**
Health care card number and expiry date: _____

Medicare No._____
(If required – for children requiring regular emergency care):

ADMINISTRATION OF MEDICATION INFORMATION

If at any time your child requires short term medication to be given at school, please request an *Administration of Medication* form to complete and return to your principal or class teacher. The school requires written authorisation from you to administer any form of medication

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 a health condition or need that ***requires support*** from school staff while he or she is in their care?
Yes ☐ - complete the remainder of this form and return to the school office. You will be given additional forms to complete.
No ☐ - sign and return to the school office. If your child's requirements change, please notify the school immediately.

List your child's health condition(s):_____
Signature: _____ Date:_____

SECTION B – IN THE FOLLOWING TABLE, PLEASE INDICATE YOUR CHILD'S CONDITION WHICH REQUIRES 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	Tick health condition	Will school staff require specific training to support your child?
Severe Allergy/Anaphylaxis	☐	YES ☐ NO ☐
Minor & Moderate Allergies	☐	YES ☐ NO ☐
Diabetes	☐	YES ☐ NO ☐
Seizures	☐	YES ☐ NO ☐
Asthma	☐	YES ☐ NO ☐
Activities Of Daily Living	☐	YES ☐ NO ☐
Other Conditions or Needs (Please specify)		
	☐	YES ☐ NO ☐
	☐	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

Name: **Date of Birth:** **School:** JOONDALUP EDUCATION SUPPORT CENTRE

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:_____

Signature:

Parent/Carer Signature: _____ Date: _____

Parent/Care Name: _____

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 a 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: / /