FORM 1 – STUDENT HEALTH CARE SUMMARY

SECTION A

School: AVELEY SECONDARY COLLEGE	Year level:
Student's Name:	Date of Birth:
Address:	Gender:

FAMILY CONTACT DETAIL	MEDICAL DETAILS
Name: _____ Relationship to student: _____ Tel: (W): _____ (H): _____ (M): _____	Medical Practice: _____ Doctor 1: _____ Telephone: _____ Doctor 2: _____ Telephone: _____ Dental Practice: _____ Name of Dentist: _____ Telephone: _____ I give permission for the School to seek medical/dental attention for my child as required. Yes ◯ No ◯ Do you have ambulance insurance? Yes ◯ No ◯ Insurance Provider: **If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.**
Name: _____ Rel. to student: _____ Tel: (W): _____ (H): _____ (M): _____	List any essential information that could affect your child in an emergency e.g. allergy to penicillin. _____ Medicare No. (If required – for children requiring regular emergency care): Card Number: _____ Expiry Date: _____

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?

If 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:** _____

No further action is required – PLEASE RETURN THIS FORM TO THE COLLEGE

If Yes ◯ - please complete the remainder of this form overleaf and return to the school office. You will be given additional forms to fill. 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	**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 of Needs (Please specify)		YES NO
		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
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:_____

Required Signatures:

Parent/Carer Signature:_____ Date: _____

Parent/Carer Signature:_____ Date: _____

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:____/____/____