Department of Education

GOVERNMENT OF WESTERN AUSTRALIA

Cloverdale PRIMARY SCHOOL

FORM 1
STUDENT HEALTH CARE SUMMARY

SECTION A

Year | **Form** | **Teacher**

Student's name

Date of birth (dd/mm/yy) / / **Gender** ◯ Male ◯ Female ◯ Not Specified

Address

Postcode

FAMILY CONTACT DETAILS

Name

Relationship to student

Address

Postcode

Telephone (Home) | **Telephone (Work)**

Telephone (Mobile)

Name

Relationship to student

Address

Postcode

Telephone (Home) | **Telephone (Work)**

Telephone (Mobile)

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
☐ **Other Conditions or Needs** (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** / /