

FORM 2 - GENERIC HEALTH CARE MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: _____ **DOB:** _____ **Year:** _____ **Form:** _____ **Teacher:** _____

Section A – Health Care Planning – to be completed by the parent/carer

Name of your child's health condition or need:

Daily Management Planning (if required):

Section B – Emergency Response Plan (if required) – To be completed by parent/carer and or medical practitioner

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 a 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 Instructions (Note: Medication must be provided by parents/carers with the original packaging and provided in the correct prescribed dose. The school will not cut tablets.)

	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 <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Storage instructions Tick appropriate box(es)	Stored at school <input type="checkbox"/>	Kept and managed by self <input type="checkbox"/>	Refrigerate <input type="checkbox"/>	Keep out of sunlight <input type="checkbox"/>	Other <input type="checkbox"/>	

Name: _____ DOB: _____ Year: _____ Form: _____ Teacher: _____

Section E –Authority to Act.

I/we authorise school staff to provide health care support for my/our child in accordance with the above plan and/or the **attached plan from a medical practitioner**. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent/Carer:	Medical Practitioner: If required (At the principal's discretion)
Date:	Date:
Review Date:	

OFFICE USE ONLY

Date received: / /	Date uploaded on SIS: / /
Is specific staff training required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Type of training:

Training service provider:

Name of person/s to be trained:

Date of training:

When completed, please attach to the *Student Health Care Summary* form.