



STUDENT HEALTH CARE SUMMARY

Name		Year	
Date of Birth		Home Room	
		Gender	Male/Female

SECTION A

Current students

There **has** been a change to my child's health that will require support from the College staff.

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

Complete sections C and D and return the form to the College Reception.

SECTION B

New students

ADMINISTRATION OF MEDICATION

Written authorization 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 a *Short Term/Medication Administration at School* form to complete and return to the College.

Note: All medication required must be supplied by the Parents/Guardians.

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?

Note: *If your child is enrolled in TAFE 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?

No **Sign and return this form to the College Reception. If you child's requirements change, please notify the College.**

Name/Signature: _____ Date: _____

Yes **Complete sections C & D and return the form to the College Reception. You will be given additional forms to complete.**

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



SECTION C

IN THE FOLLOWING TABLE, PLEASE INDICATE YOUR CHILDS CONDITION (S) WHICH REQUIRE THE SUPPORT OF THE COLLEGE 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 College staff require specific training to support your child?	
Severe Allergy/Anaphylaxis	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Minor and Moderate Allergies	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seizures	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Activities of Daily Living	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other conditions or needs (please specify):		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Has your child's Medical Practitioner provided a Health Care Plan to assist the College manage the condition?
 Yes No If yes, please provide a copy to the College.

If you have ticked Yes for specific training, please discuss the type of training needed with the Principal.

SECTION D: MEDIC ALERT INFORMATION

Does your child have a Medic Alert bracelet or pendant? Yes No

If yes, please provide details: _____

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name: _____

ON COMPLETION OF THIS FORM, PLEASE REQUEST AND COMPLETE THE RELEVANT HEALTH CARE PLAN(S).

Wherever appropriate, students should be encouraged to participate in their health care planning.

OFFICE USE ONLY

Does the child have a medical condition that needs to be flagged on MAZE/SEQTA?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have relevant health care plans been issued to the parent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has the Principal been informed if:		
• Specific staff training is required to support the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• The student's health care information is to be restricted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student Health Care Summary uploaded to SEQTA /alert added to MAZE (High Risk)		
Staff Signature: _____	Date _____	
Staff Name: _____		