DONNYBROOK DISTRICT HIGH SCHOOL

STUDENT HEALTH CARE SUMMARY
KINDERGARTEN – YEAR 10

SECTION A

Student's name: _____ **Year:** _____

Date of birth (dd/mm/yy): _____ **Gender** ☐ **Male** ☐ **Female** ☐ **Not Specified**

Address: _____

_____ **Postcode:** _____

FAMILY CONTACT DETAILS:

Name: _____

Relationship to the student: _____

Postal Address: _____

_____ **Postcode:** _____

Telephone (home): _____ **Mobile Number:** _____

Telephone (work): _____

Name: _____

Relationship to the student: _____

Postal Address: _____

_____ **Postcode:** _____

Telephone (home): _____ **Mobile Number:** _____

Telephone (work): _____

MEDICAL DETAILS:

Medical Practice: _____

Doctor 1: _____ **Telephone:** _____

Doctor 2: _____ **Telephone:** _____

Do you have ambulance insurance? ☐ No ☐ Yes - 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: _____

ADMINISTRATION OF MEDICATION:

Written authorisation must be provided for staff to administer any form of medication at school.

Long term medication – Complete Section B.

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 Administration Office. You will be given additional forms to complete.

List your child's health condition(s):

_____

_____

SECTION B

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? ☐ NO ☐ YES - 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? ☐ NO ☐ YES – If yes, provide details below:

_____

Parent or Carer Signature: _____ **Date:** _____

Parent or 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 Compass? ☐ 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

Student Health Care Summary was completed and uploaded on Compass: **Date:** _____