ENDEAVOUR SCHOOLS

2015 STUDENT HEALTH & PERMISSIONS FORM

This information is required for each student and will assist the schools and supervising staff in the preparation and planning of excursions and activities including classroom excursions and sporting events.
STRICTLY CONFIDENTIAL

SECTION A - STUDENT DETAILS

Student Name: _____Year: _____ Room: _____

Date of Birth: _____/_____/_____ Male (__) Female (__)

Parent/Guardian's full name/s: _____

Address: _____Post Code: _____

Contact numbers during school hours – i) _____ ii) _____

Email Address: _____

Alternative Contact if Parent/Guardian not available:

Name: _____ Telephone Number: _____

Name of Family Doctor: _____ Telephone Number: _____

I give permission for the school to seek medical attention for my child as required from the above medical centre. **Yes (__) No (__)**

Do you have Ambulance Cover? **Yes (__) No (__)** Health care card: **Yes (__) No (__)** Expiry Date: _____
If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.

Medicare Number: _____ Expiry Date: _____

Photo Permission: **Yes (__) No (__)** Permission to speak to the School Chaplain: **Yes (__) No (__)**

List any essential information that could affect your child in an emergency e.g. allergy to penicillin.

_____

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 front office.

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 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?

Please turn over…../

Does your child have one or more health condition(s) that will **require support** from school staff?

No (__) – sign below and return Section A of this form to the school office. If your child's requirements change, please notify the school immediately.

Signature: _____ Date: _____

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**.** You will be given further forms to complete for specific health conditions.

Health Condition	**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 or Needs (please specify)

_____

Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition? **Yes (__)** - If yes, please arrange to discuss the type of training needed with the Principal **No (__)**

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 medication 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 (__)** If yes, please attach photo to the relevant health care plan(s). **No (__)**

SECTION D – MEDIC ALERT INFORMATION

Does your child have a Medic Alert bracelet or pendant? **Yes (__) No (__)**

If yes, please provide details: _____

Parent/carer Name: _____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 (__)
Has the Principal been informed if the student's health care information is to be restricted?	Yes (__) No (__)
Date *Student Health Care Summary* was completed and uploaded on SIS:	___/___/___