

## 2019 STUDENT HEALTH &amp; 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 (Please complete using BLACK pen)**

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 (\_\_\_)** Ambulance Insurance Provider \_\_\_\_\_  
(If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance).

Medicare Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Health Care Card: **Yes (\_\_\_) No (\_\_\_)** Card No. \_\_\_\_\_ Exp. Date: \_\_\_\_\_Photo Permission (anything connected to the school): **Yes (\_\_\_) No (\_\_\_)**

The School Chaplain is available to **ALL** students. Please advise the office if you do **NOT** wish your child to access this service.

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 <i>Student Health Care Summary</i> was completed and uploaded on SIS:		___/___/___