

# 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)

	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"/>	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"/>	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: Date: Review Date:	Medical Practitioner: If required (At the principal's discretion) Date:
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**OFFICE USE ONLY**

Date received: / / Date uploaded on SIS: / /

Is specific staff training required? Yes  No : 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.**