FORM 2 - GENERIC HEALTH CARE MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: **Date of Birth:**

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

	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 Requires assistance	☐ ☐	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage instructions Tick appropriate box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

Name:	**Date of Birth:**
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:	Medical Practitioner: If required (At the principal's discretion) Date:
Review Date:	

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.