ST THOMAS' PRIMARY – STUDENT HEALTH CARE SUMMARY

SECTION A

School:	Year: Teacher:
Student's Name:	Date of Birth:
Address:	Gender: Male/Female

FAMILY CONTACT DETAIL	MEDICAL DETAILS
Name: Relationship to student:	Medical Practice: Doctor 1: Telephone: Doctor 2: Telephone: Dental Practice: Name of Dentist: Telephone
Address:	I give permission for the school to seek medical/dental attention for my child as required. Yes ☐ No ☐
Telephone: (W) (H) (M)	Do you have ambulance insurance? Yes ☐ No ☐ Insurance Provider: **If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.**
Name: Relationship to student:	List any essential information that could affect your child in an emergency e.g. allergy to penicillin.
Address:	Health care card: Yes ☐ No ☐ Expiry Date Card Number
Telephone: (W) (H) (M)	Medicare No. (If required – for children requiring regular emergency care): Card Number: Expiry Date:

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 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 ☐**
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?
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:_____
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
(In response to the information below, you will be given further forms for specific health conditions to complete)

Health Conditions	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)		
	☐	YES ☐ NO ☐
	☐	YES ☐ NO ☐
Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition?		YES ☐ NO ☐ If yes, advise the Principal

If you have ticked "Yes" for specific staff training, please discuss the type of training needed with the Principal.

Name: **Date of Birth:** **School: St Thomas' Primary**

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? Yes ☐ No ☐
If yes, provide details:_____

Signature:

Parent/Carer Signature: _____ Date: _____

Parent/Care Name: _____

ON COMPLETION OF THIS FORM, PLEASE REQUEST AND COMPLETE THE RELEVANT HEALTH CARE PLANS FROM THE ADMINISTRATION. admin@stthomas.wa.edu.au

Note: Where appropriate students should be encouraged to participate in their health care planning.

THE INFORMATION CONTAINED ON THIS FORM REMAINS VALID FOR 12 MONTHS. IF THERE ARE ANY CHANGES TO YOUR CHILD'S MEDICAL CONDITION OR MEDICATIONS NEW FORMS MUST BE COMPLETED AND RETURNED TO SCHOOL ADMINISTRATION SHOWING UPDATED INFORMATION.

Office Use Only

Does the child have an allergy that needs to be flagged on AOS? 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 ☐

Date *Student Health Care Summary* was completed and uploaded on AOS: / /