



Health Care Plan 2020

Student
Photo

Student Name: _____ Date of Birth: ____/____/____

Parent Contact:		Mobile		Home	
Parent Contact:		Mobile		Home	
Parent email:					
Student Address:					
Emergency Contact		Mobile		Home	
Relationship to student:					
Medicare Number:				GP/Doctor name:	
Reference Number:				Phone Number:	
				Specialist name:	
				Phone Number:	
Disability					
Communication	<input type="checkbox"/> Verbal <input type="checkbox"/> Non - Verbal				
Mobility	<input type="checkbox"/> Moves Independently <input type="checkbox"/> Requires assistance to move				
Behaviour	<input type="checkbox"/> Compliant <input type="checkbox"/> Non - Compliant <input type="checkbox"/> Aggression				
Regular Home Medications & Times:			Regular School Medications & Times:		
Name	Dosage	Time	Name	Dosage	Time
Medical Conditions ✓	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma				
	<input type="checkbox"/> Tube <input type="checkbox"/> Diabetes <input type="checkbox"/> Shunt				
ADDITIONAL PLANS ARE REQUIRED	<input type="checkbox"/> Other _____				
	<input type="checkbox"/> Other _____				

Health Care Plans remain specific to meet the needs of the individual student. The following plan has been developed with my knowledge and input and will be reviewed as necessary. This information may be provided to medical and other professionals. I agree to the regular administration of medication to my child as detailed above and I understand that the decision to medicate him/her at school can be reviewed at any time by the school Principal. I also agree to inform the Principal, in writing, of any change in the nature, dosage or frequency of the medication. The overall management of your child's health care needs rests with the parents or legal guardians.

Parent/Carer Name: _____ Date: _____

Parent/Carer Signature: _____

SCAN TO STUDENT FILE - ORIGINAL TO OFFICE