



Department of Education



# FORM 1 STUDENT HEALTH CARE SUMMARY

## SECTION A

<b>Year</b>	<b>Form</b>	<b>Teacher</b>
<b>Student's name</b>		
<b>Date of birth</b> (dd/mm/yy)	/ /	<b>Gender</b> Male Female Not Specified
<b>Address</b>		
Postcode		

## FAMILY CONTACT DETAILS

<b>Name</b>	
<b>Relationship to student</b>	
<b>Address</b>	
Postcode	
<b>Telephone (Home)</b>	<b>Telephone (Work)</b>
<b>Telephone (Mobile)</b>	
<b>Name</b>	
<b>Relationship to student</b>	
<b>Address</b>	
Postcode	
<b>Telephone (Home)</b>	<b>Telephone (Work)</b>
<b>Telephone (Mobile)</b>	

## MEDICAL DETAILS

### Medical practice

Doctor 1

Telephone

Doctor 2

Telephone

**Do you have ambulance insurance?** YES NO - *If yes, specify insurance provider:*

*If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.*

**List any essential information that could affect your child in an emergency e.g. allergy to penicillin.**

Medicare Card number

Medicare Card Individual  
Reference Number (IRN)

Expiry date (dd/mm/yy) / /

## 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

Note: If your child is enrolled in a TAFE, 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?**

**Does your child have one or more health condition(s) that will require support from school staff?** (Check the box that applies)

**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 / /

**If you are completing this form online and are unable to sign this form please check this box to confirm the above information is true and correct.** Note: In the event that statements made in this application later prove to be false or misleading this application may be declined. Information supplied may need to be checked by the school.

**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)**

