

**ASHFIELD PRIMARY SCHOOL**  
**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"/>	

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**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.

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Parent/Carer:

Medical Practitioner: If required (At the principal's discretion)

Date:

Date:

Review Date:

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**OFFICE USE ONLY**

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Date received: / /

Date uploaded on SIS: / /

Is specific staff training required? Yes  No

Type of training:

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Training service provider:

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Name of person/s to be trained:

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Date of training:

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**When completed, please attach to the *Student Health Care Summary* form.**