Dear Parents and Caregivers,

It is now a requirement of the Department of Education and Communities that all students who suffer from Severe Asthma, Type 1 Diabetes, Epilepsy and Anaphylaxis have an individual health care plan to assist with the management of their condition.

The health care plan must be developed in consultation with a doctor and must be signed by the same doctor. The action plan will then need to be updated each year by your doctor and a copy given to the school.

If your child currently has an Individual Health Care Plan it is now time to review this plan and you will need to visit your doctor and complete the attached forms again.

If your child has been identified by a doctor as having Severe Asthma, Type 1 Diabetes, Epilepsy or Anaphylaxis we ask that you arrange for the following documents to be completed and signed by the doctor and returned to school no later than Friday 2 May 2014.

Please ensure each student has their own form/s completed. Siblings cannot share the same documentation. If you have any questions, please contact the school as soon as possible. We thank you for your understanding and support.

Mrs Belinda Clarke        Ms Norma Petrocco
Assistant Principal        Principal
31.3.14

Please return this section to school with the appropriate forms completed by Friday 2.5.14

Students Name: ___________________________        Class: __________

Health Condition: _______________________________________________________

Please indicate if you would like to attend a meeting to further discuss your child’s health care needs.

☐ Yes, please contact me to arrange an interview time.
☐ No, I have provided the school with all of the information required to manage my child’s health condition.

_________________________            _________________________
Signed Parent/Caregiver                  Date
# 2014 Individual Health Care Plan

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Class:</th>
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<tr>
<th>Region:</th>
<th>Western Sydney Region</th>
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<td>ERN:</td>
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<tr>
<td>Medicare Number:</td>
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<td>D.O.B:</td>
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<tr>
<td>Health Condition:</td>
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<td>Medication(s) at school:</td>
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<td>Other support at school:</td>
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| Parent / Carer: Contact 1 | Surname  
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<tbody>
<tr>
<td></td>
<td>First name</td>
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<td></td>
<td>Relationship to student</td>
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<td></td>
<td>Address</td>
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<td>Home phone</td>
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</table>
| **Parent / Carer: Contact 2** | **Surname**  
|                            | **First name**  
|                            | **Relationship to student**  
|                            | **Address**  
|                            | **Home phone**  
|                            | **Work phone**  
|                            | **Mobile phone** |
| **Other Contacts:** | **Surname**  
|                      | **First name**  
|                      | **Relationship to student**  
|                      | **Address**  
|                      | **Home phone**  
|                      | **Work phone**  
|                      | **Mobile phone** |
| **Other Contacts:** | **Surname**  
|                      | **First name**  
|                      | **Relationship to student**  
|                      | **Address**  
|                      | **Home phone**  
|                      | **Work phone**  
|                      | **Mobile phone** |
| **Medical Practitioner / Doctor Contact** | **Surname**  
|                      | **First name**  
|                      | **Address**  
|                      | **Work phone**  
|                      | **Mobile phone** |
Emergency Care Issues:

Note: An emergency care/response plan is required if the student is identified at risk of an emergency reaction.

________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Emergency Service Contacts:

Eg. Ambulance, Local Hospital, Medical Centre.

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________

Any special medical notes relating to religion, culture or legal issues:

Note: If the student is transferred to the care of medical personnel, eg paramedics, this information, will, if practicable in the circumstances, be provided to those personnel. It will be a matter for the professional judgement of the medical personnel whether to act on the information.

________________________________________________________
________________________________________________________
________________________________________________________

Please tick which of the following documents are attached:

☐ An emergency care / response plan (provided by doctor).
☐ A schedule for the administration of prescribed medication.
☐ A schedule for the administration of health care procedures.
☐ An authorisation to contact the medical practitioner.
☐ Other documents – please specify:

________________________________________________________
________________________________________________________
________________________________________________________
**Individual Health Care Plan developed in consultation with:**

This Individual Health Care Plan has been developed as a part of the learning and support plan, in consultation with those indicated below and with the knowledge and agreement of the student’s parent / caregiver. Information has been provided by:

- [ ] Student
- [ ] Parent/Carer
- [ ] GP
- [ ] Medical Specialist

**Department staff involved in Individual Health Care Plan development:**

1. ___________________________ Phone: _____________
2. ___________________________ Phone: _____________
3. ___________________________ Phone: _____________

**Health Care personnel involved in managing the student’s health at school:**

1. ___________________________ Phone: _____________
2. ___________________________ Phone: _____________
3. ___________________________ Phone: _____________

**The Individual Health Care Plan will be reviewed on:**

Note: Health Care Plans should be reviewed at least annually or when a parent notifies the school that the student’s health care needs have changed. Principals can also instigate a review of the Health Care Plan at other times.

Signature of Parent/Carer:

Date:

Signature of Principal:

Date:

NOTES:

*Information in this Individual Health and Emergency Care Plan remains specific to meet the needs of the individual student named and should not be applied to the care of any other student with similar health and emergency care needs. All Individual Health and Emergency Care Plans should take into account issues of confidentiality and privacy to ensure information about the student is treated appropriately.*

The school and Department are subject to the Health Records and Information Privacy Act 2002. The information on this form is being collected for the primary purpose of ensuring the health and safety of all students, staff and visitors to the school. It may be used or disclosed to medical practitioners, health workers including ambulance officers and nurses, government departments or other schools (government and non-government) for this primary purpose or for other related purposes and as required by law. It will be stored securely in the school.
AUTHORISATION TO CONTACT MEDICAL PRACTITIONER

This form is to be completed by the parent.

My child (student’s name) ________________________________________________ is currently enrolled or applying for enrolment at _________________________ school.

I understand that the school may need to discuss the implications of my son’s or daughter’s medical condition so that the school can consider support for him or her during school hours.

I give my permission for the doctor named below to give the school information about how to manage my son’s or daughter’s health condition at school.

Doctor information:

Name:____________________________________________________________
Address:___________________________________________________________
Phone:____________________________________________________________
Email (if known):_____________________________________________________
Fax (if known):______________________________________________________

I understand the information given may be discussed by the principal of the school with other members of the school staff, as is necessary, enabling staff to care for my child.

Signed: _________________________________________ Date:_____________
(Parent/Carer)
REQUEST TO ADMINISTER PRESCRIBED MEDICATION

Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.

Name of Prescribed Medication: ..........................................................

Prescribed for (name of medical condition): ........................................

Prescribed dosage: ............................................................................

What are you requesting the school to do? ..........................................
........................................................................................................
........................................................................................................

Special storage requirements if any eg in refrigerator: .........................

Special instructions for administering the prescribed medication/s eg must be taken with food or with a glass of water: .................................

Through information you have obtained from your doctor or acquired yourself, are you aware of any likely side effects from the prescribed medication?

Yes ☐ No ☐ If Yes, Please provide more information:
........................................................................................................
........................................................................................................

If your child administers his or her own medication at home, do you request that he or she self administers this medication at school?

Yes ☐ No ☐

Note: The Principal needs to approve a decision for a student to self administer.

If your child self administers the medication at home, what level of support do you provide? (Please describe): .................................
........................................................................................................
........................................................................................................

Name of person who will carry the medication to school: .....................
........................................................................................................
........................................................................................................

I understand the information given may be discussed by the principal of the school with other members of the school staff, as is necessary, enabling staff to care for my child.

Signed: _________________________________________ Date: ___________

(Parent/Carer)