

**SCHOOL HEALTH/MEDICAL ACTION PLAN – 2012**

**This form is to be completed for all students. Please be specific. It is vital that health details and contact details are provided.**

Student's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Parent/Caregiver: \_\_\_\_\_ Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (W)

Alternative Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (W)

Usual Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (W)

Does your child have any allergies? \_\_\_\_\_

Please indicate any emergency treatments required \_\_\_\_\_

\_\_\_\_\_

Please describe any other significant health condition your child has: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Actions to be taken by the school: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medicines to take each day at school(held by the child): \_\_\_\_\_

Name of medicine: \_\_\_\_\_

Dosage? \_\_\_\_\_ How often? \_\_\_\_\_

Medicines to be kept in the school office: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_

Dosage? \_\_\_\_\_ How often? \_\_\_\_\_

**PLEASE CONTACT THE SCHOOL IF THERE ARE ANY CHANGES TO MEDICINES**

It is the parent's responsibility to talk with the family doctor about their child's medical condition. Should any of the above details change it is the parent's responsibility to inform the school.

In the event of sickness or accident and your not being able to be contacted, do you agree to the school contacting a doctor or sending the child to hospital if further treatment is required. YES / NO

I agree to the school administering medicines to my child as above or in an emergency. YES / NO

I understand the school will inform me if medicine is used by the school in an emergency.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_