Spencer Park Primary School
STUDENT HEALTH CARE SUMMARY

E3

SECTION A
STUDENT DETAILS

Family Name ______________________ Given Name______________________

Year ____________ Form ____________ Teacher ______________________

Date of birth ______________________ Gender ☐ Male ☐ Female

Address ______________________ Postcode ____________

FAMILY CONTACT DETAILS

Full Name ______________________ Relationship to student ______________________

Address ______________________ Postcode ____________

Telephone – Home ____________ Telephone – Work ____________ Mobile ____________

Full Name ______________________ Relationship to student ______________________

Address ______________________ Postcode ____________

Telephone – Home ____________ Telephone – Work ____________ Mobile ____________

FOR WATER BASED EXCURSIONS (Not applicable to Pre-Primary and Kindergarten children.)

Swimming Ability

1. Beginner	4. Water Awareness*	7. Intermediate	10. Junior Swim and Survive*
2. Water Discovery*	5. Water Sense	8. Water Wise*	11. Swim and Survive*
3. Preliminary	6. Junior	9. Senior	12. Senior Swim & Survive*

My child has achieved stage number __________ Date achieved __________ OR I am unsure. Please assess my child. ☐

Other Comments ______________________

SCHOOL PHOTOGRAPHS

I give permission for photographs of my child to be taken for newsletters and for the local media should this be required. ☐ Yes ☐ No

MEDICAL DETAILS

Doctor 1 ____________ Telephone ____________ Doctor 2 ____________ Telephone ____________

Dental Practice ____________ Dentist ____________ Telephone ____________

I give permission for the school to seek medical/dental attention for my child as required. ☐ Yes ☐ No

Do you have ambulance insurance? ☐ Yes ☐ No 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 (for example, allergy to penicillin).

____

Health Care card? ☐ Yes ☐ No Expiry Date ____________ Card Number ____________

Medicare Number (for children requiring regular emergency care) ____________ Expiry Date____________

ADMINISTRATION OF MEDICATION (ALL medication required must be supplied by parents/carers.)

Written authorization 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.

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 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?

☐ 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 ____________

☐ 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) ______________________

SECTION B

In the following table, please indicate your child's condition(s) which require the support school staff.
(In response to the information below, you will be given further forms for specific health conditions to complete.)

Health Conditions	Tick health Condition	Will school staff require specific training to support your child?
Severe allergy/Anaphylaxis	☐	Yes ☐ No ☐
Minor and Moderate Allergies	☐	Yes ☐ No ☐
Diabetes	☐	Yes ☐ No ☐
Seizures	☐	Yes ☐ No ☐
Asthma	☐	Yes ☐ No ☐
Activities of Daily Living	☐	Yes ☐ No ☐
Other Conditions or Needs (please specify)		
	☐	Yes ☐ No ☐
	☐	Yes ☐ No ☐
Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition?		Yes ☐ No ☐ If yes, advise the Principal.
If you have ticked "Yes" for specific staff training, please discuss the type of training needed with the Principal.		

SECTION C: CONSENT FOR PHOTO IDENTIFICATON ON YOUR CHILD'S HEALTH CARE PLAN

If your child has a condition where an emergency may occur, please indicate whether you give consent for staff to place your child's medical details and photo on view to provide immediate identification.

I give permission for my child's "medical details and photo" to be on view for staff. Yes ☐ No ☐

If yes, please attach photo to the relevant health care plan(s).

SECTION D: MEDIC ALERT INFORMATION

Does your child have a Medic Alert bracelet or pendant? Yes ☐ No ☐

If yes, provide details. ____

____

Parent/Carer Name ________________ Parent/Carer Signature ________________ Date ________

ON COMPLETION OF THIS FORM, PLEASE REQUEST AND COMPLETE THE RELEVANT HEALTH CARE PLANS.
Note: Where appropriate, students should be encouraged to participate in their health care planning.

Office Use Only		
Does the child have an allergy that needs to be flagged on SIS	Yes ☐ No ☐	Date ________
Have relevant health care plans been issued to the parent?	Yes ☐ No ☐	Date ________
Has the Principal been informed if:		
• Specific training is required to support the teacher?	Yes ☐ No ☐	
• The student's health care information is to be restricted?	Yes ☐ No ☐	
Date *Student Health Care Summary* was completed and uploaded on SIS.	Date ________	