# Parent Consent and Acceptance Form

**Student's Full Name:** _____

**Parent/Guardian Consent – please circle response below as appropriate – (if left blank we will assume yes is the response):**
The information about your child/dependant and family collected through this form will only be shared with school staff who need to know to enable our school to educate or support your child/dependant, or to fulfil legal obligations including duty of care, anti-discrimination law and occupational health and safety law. The information collected will not be disclosed beyond the Department of Education without your consent, unless such disclosure is lawful. For more about information-sharing and privacy, see our school's privacy policy: Data will be kept permanently as per the 2018 Retention and Disposal Authority for Records of School Records 3.3.1 Summary Enrolment Records requires. The collection and use of the students personally identifiable information via consent forms provided within the handbook and stored via Cumulus is done in accordance with the Privacy and Data Protection Act 2014. Data will be kept permanently as per the 2018 Retention and Disposal Authority for Records of School Records 3.3.1 Summary Enrolment Records requires.

| | | |
|---|---|---|
| I agree to my child/dependent using the internet and computer network at Outdoor School in accordance with the same internet student user's agreement that applies at their current school. | Yes | No |
| I also consent to my child/dependent being photographed and/or visual images of my child/dependent being taken whilst at Outdoor School by the DE. I also consent to these photos being used for use in the school's publications, the school's social media accounts and the school's website, for publicity purposes without acknowledgment and without being entitled to any remuneration or compensation. | Yes | No |
| Is English your child/dependent's main language? | Yes | No |
| Is your child/dependent of Aboriginal or Torres Strait Islander origin? | Yes | No |
| Has your child/dependent been away from home before? | Yes | No |
| I authorise the teacher in charge to administer paracetamol as per the Outdoor School protocol. | Yes | No |
| I understand that I will be required to immediately collect my child/dependent from Outdoor School if they are unwell and unable to participate in the program while at Outdoor School. | Yes | No |
| I understand that should my child/dependent violate the rules outlined in the **Outdoor School Student Code of Cooperation** to the extent that the teacher in charge in consultation with the Principal of Outdoor School Outdoor School considers that they should be sent home, I agree to organise this withdrawal and fully cover the transport costs involved in this process. | Yes | No |

I have read the **Parent/Guardian and Student Booklet** and the **Outdoor School Enrolment/Acceptance Policy** included in the booklet and I agree to my child/dependant's attendance at the Outdoor School - Outdoor School on:

**_____/_____/_____ (Starting Date)**

I have read the **Parent/Guardian and Student Booklet** and I agree to them taking part in any excursion or activities arranged for students in connection with the school program. I understand the program contains potentially hazardous activities in remote areas subject to natural hazards and severe weather.

I will notify the school if my child/dependant is in contact with any infectious disease within four weeks of departure date. In the event of any illness or accident, where it is impracticable to communicate with me, I authorise the teacher in charge to consent to my child/dependant receiving such medical or surgical treatment as may be deemed necessary. I accept responsibility for payment of any expenses thus incurred. In the event of my child/dependant being unable to accompany the rest of the group home due to ill health or accident I will make the necessary arrangements in liaising with the School Principal for their return.

I agree to ensure that my child/dependant's mobile devices (phones, tablets, iPods etc.) remain at home whilst they attend this program.

_____ _____ _____

**Parent/Guardian's Full Name (please print)** **Parent/Guardian's Signature** **Date**

I have read the **Outdoor School Student Code of Cooperation** and I hereby undertake that while travelling to and from the school and while in attendance I shall behave in a good and proper manner and shall observe whatever rules are decided on as best for the welfare of all.

_____ _____

**Student's Signature** **Date**

***Cancellation or Withdrawal***

*The Department of Education (DE) reserves the right to cancel a program for any reason. In the event of a student's application being withdrawn prior to the commencing date of the program the DE through the Principal reserves the right to make a refund only where a reasonable excuse for withdrawal is offered. No refund will be made where a student leaves during the program except in the case of illness, and then only on a pro rata basis*

# Medical Information Form

If there is a situation or incident which requires first aid to be administered to your child, school staff will administer first aid that is reasonably necessary and appropriate to their level of training. School staff will also seek emergency medical attention for your child if it is considered reasonably necessary. Any costs associated with student injury rest with parents/carers unless the Department of Education is liable in negligence (liability is not automatic).
In the event that your child needs medical attention, school staff will contact you as soon as practically possible.

School: _____ Year Level or Visiting Staff: _____

Full Name: _____

Student Date of Birth: _____ Student Gender: Female ☐ Male ☐ Gender Diverse ☐

Parent/Guardian or Next of Kin Full Name: _____

Address: _____

Parent/Guardian or Next of Kin Mobile Phone: _____ Other Phone: _____

Home Email Address: _____

| Tick | Item | Details |
|---|---|---|
| | Diabetes - Type | |
| | Dietary Requirements | |
| | Dizzy Spells/Blackouts | |
| | Fits of Any Type | |
| | Hay Fever | |
| | Heart Condition | |
| | Migraines | |
| | Physical Difficulties | |
| | Previous Injuries - When | |
| | Sleepwalking | |
| | Bed Wetter | |
| | Mental Health eg ADHD | |
| | Travel Sickness | |
| | Other | |

*Please tick the box on the left if your child/dependant suffers any of the following:*

☐ Anaphylaxis | If ticked, you **MUST** attach the appropriate completed Anaphylaxis Action Plan.
Please state w*ho will carry the Epipen*

☐ Allergies | If ticked, you **MUST** complete and attach the Allergic Reactions Action Plan.

☐ Asthma | If ticked, you **MUST** provide your child's personal Asthma Action Plan. A suitable blank form is enclosed.

☐ Other Health Support Needs | If ticked provide a Student Health Support Plan if your child's needs medical or health related support at school (e.g. diabetes management).

☐ Support for Learning | Does your child/dependant have additional needs and require support?
If ticked you must complete the **Student Learning Needs Form.**

| **Year of Last Tetanus Immunisation** (If known): | |
|---|---|

**Swimming Ability:** please tick the distance your child/dependant can swim comfortably.

☐ Cannot Swim ☐ Weak Swimmer (<50m) ☐ Fair Swimmer (50-100m) ☐ Competent Swimmer (100-200m) ☐ Strong Swimmer (200m+)

**Medication –** Is your child/dependant presently taking tablets and or medicine? ☐ Yes ☐ No

**If yes, please complete the Medication Authority Form.**

**Parent/Guardian Signature:** _____ **Date:** _____

# Medication Authority Form

**For students requiring medication to be administered at school. This form is not required if a student does not have any medications.** This form should, be signed by the student's medical/health practitioner for all medication to be administered at school but schools may proceed on the signed authority of parents in the absence of a signature from a medical practitioner.

- **For students with asthma**, Asthma Action Plan
- **For students with anaphylaxis**, an ASCIA Action Plan for Anaphylaxis

Please only complete the sections below that are relevant to the student's health needs. If additional advice is required, please attach it to this form.

**Student Details:**

Name of school: _____

Name of student: _____ Date of Birth: _____

**Medication to be administered at school:**

| Medication Name | What is the medication taken for | When is it administered | Dosage and Method of administering the Medication | Supervision level required |
|---|---|---|---|---|
| | | | | ☐ No – student self-managing<br>☐ Yes<br>☐ remind ☐ observe<br>☐ assist ☐ administer |
| | | | | ☐ No – student self-managing<br>☐ Yes<br>☐ remind ☐ observe<br>☐ assist ☐ administer |

**Medication delivered to the school:**

Please indicate if there are any specific storage instructions for any medication:

Please ensure that medication delivered to the school:

☐ Is in its original package.

☐ The pharmacy label matches the information included in this form.

**Supervision required:**

Students in early years will generally need supervision of their medication and health care management. In line with their age, stage of development and capabilities, older students can take responsibility for their health care. Self-management should be agreed to by the student, their parents, the school and the student's medical practitioner. Please describe what supervision or assistance is required by the student when taking medication at school (e.g. remind, observe, assist or administer):

**Monitoring effects of medication:**

Please note: School staff ***do not*** monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

**Privacy Statement:**

We collect personal and health information to plan for and support the health care needs of our students. Information collected will be used and disclosed in accordance with the Department of Education and Training's privacy policy which applies to all government schools (available at: http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx) and the law.

**Authorisation to administer medication in accordance with this form:**

Name of parent/carer: _____

Signature: _____ Date: _____

Name of medical/health practitioner: _____

Professional Role:

Signature: _____ Date: _____

# Student Learning Needs Form

**ONLY complete this form if your child has specific additional learning needs. Students with an Individual Learning Plan or an Education Action Plan should have this form completed as well as including their plan.**

**Student Name: _____**

**Please indicate any adjustments that may assist your child/dependant to participate at school:**

Has your child/dependant received individualised disability funding before? If yes, please specify below. ☐ Yes ☐ No

Does your child/dependant have additional needs in one of the following areas? ☐ Yes ☐ No

Speech/Language: ☐ No ☐ Yes (please specify):

Physical: ☐ No ☐ Yes (please specify):

Cognitive/Learning: ☐ No ☐ Yes (please specify):

Social/Emotional: ☐ No ☐ Yes (please specify):

**Is the student on:** ☐ An Individual Learning Plan ☐ An Education Plan

Please list below other relevant information that would assist us to work with your child/dependant in a residential environment.

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

**Signature of Parent/Guardian:** **Date:**

# ASTHMA ACTION PLAN

Take me when you visit your doctor

ASTHMA AUSTRALIA

Photo (optional)

**Name:**

**Plan date:** **Review date:**

**Doctor details:**

**EMERGENCY CONTACT**

**Name:**

**Phone:**

**Relationship:**

## WELL CONTROLLED is all of these...

- ☑ needing reliever medicine no more than 2 days/week
- ☑ no asthma at night
- ☑ no asthma when I wake up
- ☑ can do all my activities

Peak flow reading (if used) above _____

**TAKE preventer**

Name

morning ____ night ____ puffs/inhalations

- Use my preventer, even when well controlled
- Use my spacer with my puffer

**TAKE reliever**

Name

____ puffs/inhalations as needed ____ puffs/inhalations 15 minutes before exercise

- Always carry my reliever medicine

## FLARE-UP Asthma symptoms getting worse such as any of these...

- needing reliever medicine more than usual OR more than 2 days/week
- woke up overnight with asthma
- had asthma when I woke up
- can't do all my activities

Peak flow reading (if used) between _____ and _____

My triggers and symptoms

**TAKE preventer**

Name

morning ____ night ____ puffs/inhalations for ____ days then back to **well controlled** dose

**TAKE reliever**

Name ____ puffs/inhalations as needed

**START other medicine**

Name/dose/days/other treatments

**MAKE appointment to see my doctor same day or as soon as possible**

## SEVERE Asthma symptoms getting worse such as any of these...

- reliever medicine not lasting 3 hours
- woke up frequently overnight with asthma
- had asthma when I woke up
- difficulty breathing

Peak flow reading (if used) between _____ and _____

My triggers and symptoms

**TAKE preventer**

Name

morning ____ night ____ puffs/inhalations for ____ days then back to **well controlled** dose

**TAKE reliever**

Name ____ puffs/inhalations as needed

**START other medicine**

Name/dose/days/other treatments

**MAKE appointment to see my doctor TODAY**

- If unable to see my doctor, visit a hospital

**OTHER INSTRUCTIONS**

Other medicines, treatments, dose, duration, etc

## EMERGENCY is any of these...

- reliever medicine not working at all
- can't speak a full sentence
- extreme difficulty breathing
- feel asthma is out of control
- lips turning blue

Peak flow reading (if used) below _____

1 000 **CALL AMBULANCE NOW**

Dial Triple Zero (000)

2 **START ASTHMA FIRST AID**

Turn page for Asthma First Aid

**If you are using a dual purpose reliever, your doctor will discuss the correct plan for you.**

v19 Updated 13 October 2023

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

# ACTION PLAN FOR Anaphylaxis

Name: _____ Date of birth: DD / MM / YYYY

Confirmed allergen(s): _____

_____

Family/emergency contact(s):

1. _____ Mobile: _____

2. _____ Mobile: _____

Plan prepared by: _____ (doctor or nurse practitioner) who authorises medications to be given, as consented by the parent/guardian, according to this plan.

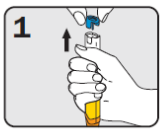
Signed: _____ Date: DD / MM / YYYY

Antihistamine: _____ Dose: _____

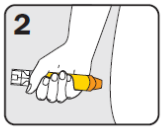
This plan does not expire but review is recommended by: DD / MM / YYYY

## How to give adrenaline (epinephrine) injectors

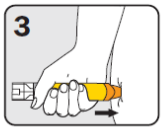
### EpiPen®




Form fist around EpiPen® and PULL OFF **BLUE** SAFETY RELEASE



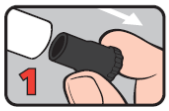

Hold leg still and PLACE **ORANGE** END against outer mid-thigh (with or without clothing)



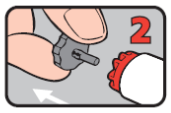

PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds REMOVE EpiPen®

**EpiPen® is prescribed as follows:**
EpiPen® Jr (150 mcg) for children 7.5-20kg
EpiPen® (300 mcg) for children over 20kg and adults

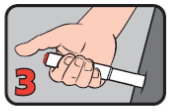
### Anapen®



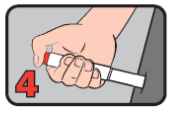

PULL OFF **BLACK** NEEDLE SHIELD




PULL OFF **GREY** SAFETY CAP from red button




PLACE NEEDLE END FIRMLY against outer mid-thigh at 90°angle (with or without clothing)




PRESS **RED** BUTTON so it clicks and hold for 3 seconds. REMOVE Anapen®

**Anapen® is prescribed as follows:**
Anapen® 150 Junior for children 7.5-20kg
Anapen® 300 for children over 20kg and adults
Anapen® 500 for children and adults over 50kg

## MILD TO MODERATE ALLERGIC REACTIONS

**SIGNS:**
- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

**Mild to moderate allergic reactions may not always occur before anaphylaxis**

**ACTIONS:**
- Stay with person, call for help
- Locate adrenaline injector
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

## SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

**Watch for ANY ONE of the following signs:**
- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)

## ACTIONS FOR ANAPHYLAXIS

**1 LAY PERSON FLAT - do NOT allow them to stand or walk**
- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



**2 GIVE ADRENALINE INJECTOR**

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

**IF IN DOUBT GIVE ADRENALINE INJECTOR**

Commence CPR at any time if person is unresponsive and not breathing normally

**ALWAYS GIVE ADRENALINE INJECTOR FIRST, and then asthma reliever puffer** if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

© ASCIA 2023 This plan is a medical document that can only be completed and signed by the patient's doctor or nurse practitioner and cannot be altered without their permission.

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

# ACTION PLAN FOR Allergic Reactions

Name: _____ Date of birth: DD / MM / YYYY

Confirmed allergen(s): _____

_____

Family/emergency contact(s):

1. _____ Mobile: _____

2. _____ Mobile: _____

Plan prepared by: _____ (doctor or nurse practitioner) who authorises medications to be given, as consented by the patient or parent/guardian, according to this plan.

Signed: _____ Date: DD / MM / YYYY

Antihistamine: _____ Dose: _____

This plan does not expire but review is recommended by: DD / MM / YYYY

This ASCIA Action Plan for Allergic Reactions is for people who have allergies but do not have a prescribed adrenaline (epinephrine) injector.

## MILD TO MODERATE ALLERGIC REACTIONS

### SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting -
  **these are signs of anaphylaxis for insect allergy**

**Mild to moderate allergic reactions may not always occur before anaphylaxis**

### ACTIONS:

- Stay with person, call for help
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

## SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

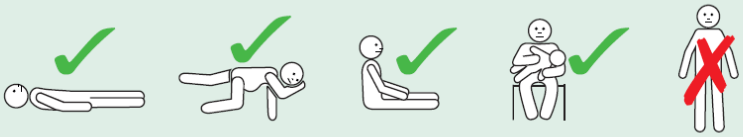
### Watch for ANY ONE of the following signs:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)

## ACTIONS FOR ANAPHYLAXIS

### 1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



### 2 GIVE ADRENALINE INJECTOR IF AVAILABLE

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Transfer person to hospital for at least 4 hours of observation

### IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

Adrenaline injector doses are:

- 150 mcg for children 7.5-20kg
- 300 mcg for children over 20kg and adults
- 300 mcg or 500 mcg for children and adults over 50kg

Instructions are on device labels.

**ALWAYS GIVE ADRENALINE INJECTOR FIRST and then asthma reliever puffer** if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

© ASCIA 2023 This plan is a medical document that can only be completed and signed by the patient's doctor or nurse practitioner and cannot be altered without their permission.

# STUDENT HEALTH SUPPORT PLAN - Cover Sheet

This plan outlines how the school will support the student's health care needs, based on health advice received from the student's medical/health practitioner. This form must be completed for each student with an identified health care need (not including those with Anaphylaxis as this is done via an Individual Anaphylaxis Management Plan – see Anaphylaxis)

**This Plan is to be completed by the principal or nominee in collaboration with the parent/carer and student.**

| | |
|---|---|
| School: | Phone: |
| Student's name: | Date of birth: |
| Year level: | Proposed date for review of this plan: |

| Parent/carer contact information (1) | Parent/carer contact information (2) | Other emergency contacts (if parent/carer not available) |
|---|---|---|
| Name: | Name: | Name: |
| Relationship: | Relationship: | Relationship: |
| Home phone: | Home phone: | Home phone: |
| Work phone: | Work phone: | Work phone: |
| Mobile: | Mobile: | Mobile: |
| Address: | Address: | Address: |

Medical /Health practitioner contact:

- ☐ General Medical Advice Form - for a student with a health condition
- ☐ School Asthma Action Plan
- ☐ Condition Specific Medical Advice Form – Cystic Fibrosis
- ☐ Condition Specific Medical Advice Form – Acquired Brain Injury
- ☐ Condition Specific Medical Advice Form – Cancer
- ☐ Condition Specific Medical Advice Form – Diabetes
- ☐ Condition Specific Medical Advice Form – Epilepsy
- ☐ Personal Care Medical Advice Form - for a student who requires support for transfers and positioning
- ☐ Personal Care Medical Advice Form - for a student who requires support for oral eating and drinking
- ☐ Personal Care Medical Advice Form - for a student who requires support for toileting, hygiene and menstrual health management

List who will receive copies of this ***Student Health Support Plan***:

1. Student's Family 2. Other: _____ 3. Other:_____

The following ***Student Health Support Plan*** has been developed with my knowledge and input

Name of parent/carer or adult/mature minor** student: _____ Signature: _____ Date: _____

***Please note: Mature minor is a student who is capable of making their own decisions on a range of issues, before they reach eighteen years of age. See: Decision Making Responsibilities for Students*

Name of principal (or nominee): _____ Signature: _____ Date: _____

**Privacy Statement**

The school collects personal information so as the school can plan and support the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information may be disclosed to relevant school staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by another law. You are able to request access to the personal information that we hold about you/your child and to request that it be corrected. Please contact the school directly or FOI Unit on 96372670.

# HOW THE SCHOOL WILL SUPPORT THE STUDENT'S HEALTH CARE NEEDS

| | |
|---|---|
| Student's name: | |
| Date of birth: | Year level: |
| What is the health care need identified by the student's medical/health practitioner? | |
| Other known health conditions: | |
| When will the student commence attending school? | |
| Detail any actions and timelines to enable attendance and any interim provisions: | |

**Below are some questions that may need to be considered when detailing the support that will be provided for the student's health care needs. These questions should be used as a guide only.**

| Support | What needs to be considered? | Strategy – how will the school support the student's health care needs? | Person Responsible for ensuring the support |
|---|---|---|---|
| **Overall Support** | Is it necessary to provide the support during the school day? | *For example, some medication can be taken at home and does not need to be brought to the school.* | |
| | How can the recommended support be provided in the simplest manner, with minimal interruption to the education and care program? | *For example, students using nebulisers can often learn to use puffers and spacers at school.* | |
| | Who should provide the support? | *For example, the principal should conduct a risk assessment for staff and ask:*<br>*Does the support fit with assigned staff duties, the scope of their position, and basic first aid training (see First Aid for Students and Staff)*<br>*Are additional or different staffing or training arrangements required?* | |
| | How can the support be provided in a way that respects dignity, privacy, comfort and safety and enhances learning? | *For example, detail the steps taken to ensure that the support provided respects the student's dignity, privacy, comfort and safety and enhances learning.* | |
| **First Aid** | Does the medical/health information highlight any individual first aid requirements for the student, other than basic first aid? | *Discuss and agree on the individual first aid plan with the parent/carer.*<br>*Ensure that there are sufficient staff trained in basic first aid (see First Aid for Students and Staff)*<br>*Ensure that all relevant school staff are informed about the first aid response for the student.* | |
| | Are there additional training modules that staff could undertake to further support the student, such as staff involved with excursions and specific educational programs or activities? | *Ensure that relevant staff undertake the agreed additional training*<br>*Ensure that there are contingency provisions in place (whilst awaiting the staff member to receive training), to facilitate the student's attendance at school.* | |

| Support | What needs to be considered? | Strategy – how will the school support the student's health care needs? | Person Responsible for ensuring the support |
|---|---|---|---|
| **Complex medical needs** | Does the student have a complex medical care need? | *Is specific training required by relevant school staff to meet the student's complex medical care need?*<br><br>*The Schoolcare Program enables students with ongoing complex medical needs to have their health care requirements met safely at school. This program is available to students who would be unable to attend school without the procedure being performed by appropriately trained staff. Following the referral process, RCH nurses will attend your school and provide specialist training to nominated school staff.*<br><br>*Further information about the Schoolcare Program may be found in the Schoolcare Program Guidelines and Referral form at: www.education.vic.gov.au/school/teachers/learningneeds/Pages/schoolcare-program.aspx* | |
| **Personal Care** | Does the medical/health information highlight a predictable need for additional support with daily living tasks? | *Detail how the school will support the student's personal care needs, for example in relation to nose blowing, washing hands, toileting care (including menstrual health management and other aspects of personal hygiene)*<br><br>*Would the use of a care and learning plan for toileting or hygiene be appropriate?* | |
| **Routine Supervision for health-related safety** | Does the student require medication to be administered and/or stored at the School? | *Ensure that the parent/carer is aware of the school's policy on medication management.*<br><br>*Ensure that written advice is received, ideally from the student's medical/health practitioner for appropriate storage and administration of the medication – via the Department's Medication Authority Form.*<br><br>*Ensure that a medication log or equivalent official medications register is completed by the person administering the taking of the medication.* | |
| | Are there any facilities issues that need to be addressed? | *Ensure the school's first aid room/sick bay and its contents provide the minimum requirements and discuss whether other requirements can be facilitated in this room to meet the student's health care needs.*<br><br>*Ensure the school provides necessary reasonable adjustments to assist a student who requires a wheelchair or other technical support. Discuss requirements and possible modifications with the parent/carer/student.* | |
| | Does the student require assistance by a visiting nurse, physiotherapist, or other health worker? | *Detail who the worker is, the contact staff member and how, when and where they will provide support.*<br><br>*Ensure that the school provides a facility which enables the provision of the health service.* | |
| | Who is responsible for management of health records at the school? | *Ensure that information privacy principles are applied when collecting, using, retaining or disposing of personal or health information.* | |

| Support | What needs to be considered? | Strategy – how will the school support the student's health care needs? | Person Responsible for ensuring the support |
|---|---|---|---|
| | Where relevant, what steps have been put in place to support continuity and relevance of curriculum for the student? | *For example, accommodation in curriculum design and delivery and in assessment for a student in transition between home, hospital and school; for a student's attendance (full-time, part-time or episodically).* | |
| **Other considerations** | Are there other considerations relevant for this health support plan? | *For example, in relation to behaviour, such as special permission to leave group activities as needed; planned, supportive peer environment.*<br><br>*For example, in relation to the environment, such as minimising risks such as allergens or other risk factors.*<br><br>*For example, in relation to communication, is there a need to formally outline the communication channels between the school, family and health/medical practitioner?*<br><br>*For example, is there a need for planned support for siblings/peers?* | |

| Support | What needs to be considered? | Strategy – how will the school support the student's health care needs? | Person Responsible for ensuring the support |
|---|---|---|---|
| **Overall Support** | | | |
| | | | |
| | | | |
| | | | |
| **First Aid** | | | |
| | | | |
| **Complex medical needs** | | | |
| **Personal Care** | | | |
| **Routine Supervision for health-related safety** | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Other considerations** | | | |