

SCHOOL HEALTH/MEDICAL ACTION PLAN

1. To be completed for all students. Please be specific. It is vital that Health Details and contact details are provided
2. Nil returns also to be returned.

Students Name: _____

Address: _____

Parent/Caregiver: _____ Phone: _____ (H) _____ (W)

Alternative Contact: _____ Phone: _____ (H) _____ (W)

Usual Doctor: _____ Phone: _____ (H) _____ (W)

Please describe any 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: _____

How much? _____ How often? _____

Medicines to be kept in the school office: _____

Name of medicine: _____

How much? _____ 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 parents 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 it is serious? *Yes / No (Please circle one)*

I agree to the school administering medicines to my child as above or in an emergency.

I agree to the school administering panadol to my child for fever and pain relief with discretion.

Signed: _____ **Date:** _____