Department of Education
GOVERNMENT OF WESTERN AUSTRALIA

Djidi Djidi Aboriginal School

FORM 1
STUDENT HEALTH CARE SUMMARY

SECTION A

Year | **Form** | **Teacher**

Student's name

Date of birth (dd/mm/yy) / / **Gender** ◯ Male ◯ Female ◯ Not Specified

Address

Postcode

FAMILY CONTACT DETAILS

Name

Relationship to student

Address

Postcode

Telephone (Home) | **Telephone (Work)**

Telephone (Mobile)

Name

Relationship to student

Address

Postcode

Telephone (Home) | **Telephone (Work)**

Telephone (Mobile)

MEDICAL DETAILS

Medical practice

Doctor 1 **Telephone**

Doctor 2 **Telephone**

Do you have ambulance insurance? ◯ YES ◯ NO *- If yes, specify 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 *e.g. allergy to penicillin.*

Medicare Card number **Medicare Card Individual Reference Number (IRN)**

Expiry date (dd/mm/yy) / /

ADMINISTRATION OF MEDICATION

Written authorisation 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.
Note: All medication required must be supplied by parents/carers.

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 care 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? (Check the box that applies)

☐ **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** / /

☐ **If you are completing this form online and are unable to sign this form please check this box to confirm the above information is true and correct.** Note: In the event that statements made in this application later prove to be false or misleading this application may be declined. Information supplied may need to be checked by the school.

☐ **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)