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| --- | --- | --- | --- | --- |
| Student’s name: |  | | | |
| Date of birth: |  | | | |
| Health condition(s):  (if anaphylactic, also list allergens) |  | | | |
| Medication at school: |  | | | |
| Storage location: |  | | | |
| Medication dose: |  | | | |
| Time to be taken: |  | | | |
| Start date: |  | Finish Date: | |  |
| Parent/carer contact: | **Parent information (1)**  Name(s):  Relationship to child:      Mother  Address:  Home phone:  Work phone:  Mobile phone: | | **Parent information (2)**  Name(s):  Relationship to child:      Father  Address:  Home phone:  Work phone:  Mobile phone: | |
| Other emergency contacts (if parent unavailable) | **Name(s):**  Relationship to child:  Address:  Home phone:  Work phone:  Mobile phone: | | | |
| Medical practitioner contact: | **Name:**  Address:  Phone:  Email (if known): | | Mobile (if known):  Fax (if known): | |
| Emergency care provided at school: |  | | | |

Strategies for specific activities:

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| --- | --- | --- |
| **Risk** | **Strategy to eliminate or minimise risk** | **Who is responsible for implementation?** |
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The following individual health care plan has been developed with my knowledge and input and will be reviewed next year on (insert date of proposed review).

Signature of parent/carer: …………………………………………………… Date

Signature of principal or delegate: …………………………………… Date …………………………….