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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:      MotherAddress:      Home phone:      Work phone:      Mobile phone:       | **Parent information (2)**Name(s):      Relationship to child:      FatherAddress:      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 …………………………….