NSW GOVERNMENT Education & Communities

Public Schools NSW

Insert photo of student

Individual Health Care Plan
Cover sheet

This template forms the cover sheet for an individual health care plan. Additional information and attachments will be relevant to meet the specific health care needs of the student.

The individual health care plan must address the needs of the student in the context of the school and the activities the student will be involved in. Planning must take into account the student's full range of learning and support needs.

The individual health care plan is developed in consultation with the parent, staff and student, where practicable, and on the basis of information from the student's doctor, provided by the parent.

For more information see http://www.schools.nsw.edu.au/studentsupport/studenthealth/index.php and for students with anaphylaxis see the Anaphylaxis Procedures for Schools.

The plan will be reviewed on:
NOTE: Individual health care plans should be reviewed at least annually or when the parent notifies the school that the student's health needs have changed. Principals can also instigate a review of the health care plan at other times.

School	Lisarow PS	**Phone**	024362 1048
Principals Network	Gosford		
Student name		**Class**	
Date of birth		**Medicare number**	
ERN/Student number			
Health condition/s			
If anaphylaxis, list the confirmed allergies			
Learning and support needs of the student (including learning difficulties, behaviour difficulties and other disabilities)			
Impact of any of the conditions (as mentioned above) on implementation of this individual health care plan			

Medication/s at school		
Medication supply, storage and replacement. For anaphylaxis this will include the adrenaline autoinjector		
Other support at school		
Parent/Carer contacts:	**Parent/Carer information (1)**	
	First name	
	Surname	
	Relationship to child	
	Address	
	Home phone	
	Work phone	
	Mobile phone	
	Parent/Carer information (2)	
	First name	
	Surname	
	Relationship to child	
	Address	
	Home phone	
	Work phone	
	Mobile phone:	
Emergency contacts (if parent/carer unavailable)	First name	
	Surname	
	Relationship to child	
	Address	
	Home phone	
	Work phone	
	Mobile phone	

Medical practitioner / doctor contact:	First name	
	Surname	
	Address	
	Phone	
	Mobile (if known)	
	Email (if known)	
	Fax (if known)	

Emergency Care

Notes:
An emergency care/response plan is required if the student is diagnosed at risk of a medical emergency at school.
For students at risk of anaphylaxis the ASCIA Action Plan for Anaphylaxis is the emergency response plan. This plan is obtained by the parent from the student's doctor and not developed by the school.

Emergency Service Contacts: (eg ambulance, local hospital, medical centre)

1.

2.

3.

In the event an ambulance is called, schools can print an ambulance report from within ERN for the student.

Special medical notes.

Any special medical notes relating to religion, culture of legal issues, eg. blood transfusions.
Note: If the student is transferred to the care of medical personnel, eg. paramedics this information, will if practicable in the circumstances, be provided to those personnel. It will be a matter for the professional judgment of the medical personnel whether to act on the information.

Documents attached

Please tick which of the following documents are attached as part of the individual health care plan:

- ☐ An emergency care/response plan (for anaphylaxis this is the ASCIA Action Plan for Anaphylaxis)
- ☐ A statement of the agreed responsibilities of different people involved in the student's support
- ☐ A schedule for the administration of prescribed medication
- ☐ A schedule for the administration of health care procedures
- ☐ An authorisation for the doctor to provide health information to the school
- ☐ Other documents – please specify. *Note: For anaphylaxis this should include strategies to minimise the risk of exposure to known allergens and details of communication and staff training strategies. See the Anaphylaxis Procedures for Schools for further information.*

Consultation
This individual health care plan has been developed as part of the learning support plan, in consultation with those indicated below and overleaf and with the knowledge and agreement of the student's parent/carer. Information has been provided by:

☐ Student ☐ Parent/Carer ☐ GP ☐ Medical specialist

Department staff involved in plan development	
1.	Phone
2.	Phone
3.	Phone
4.	Phone
5.	Phone
Health care personnel involved in managing the student's health at school: (eg Community Nurse, Therapist)	
1.	Phone
2.	Phone
3.	Phone
4.	Phone
Signature of Parent/Carer:	Date
Signature of Principal:	Date

NOTES:

Information in this individual health and emergency care plan remains specific to meet the needs of the individual student named and should not be applied to the care of any other student with similar health and emergency care needs. All individual health and emergency care plans must take into account issues of confidentiality and privacy to ensure information about the student is treated appropriately.

The school and the Department are subject to the Health Records and Information Privacy Act 2002. The information on this form is being collected for the primary purpose of ensuring the health and safety of students, staff and visitors to the school. It may be used and disclosed to medical practitioners, health workers including ambulance officers and nurses, government departments or other schools (government and non-government) for this primary purpose or for other related purposes and as required by law. It will be stored securely in the school.

Request for administering prescribed medication to the student

First name: ..... Last name: .....

Date of Birth: .....

Enrolled at this school ☐ Yes ☐ No Class if currently enrolled: .....

Health/medical condition:

.....

.....

Could your child experience an emergency reaction in relation to this condition? (please tick) Yes ☐ No ☐

Note: if your child is to take more than one prescribed medication, please attach a separate request for each medication.

Name of prescribed medication: .....

Prescribed for (name of medical condition):.....

Prescribed dosage:.....

Period required: From ..... To .....

What are you requesting the school to do?.....

.....

Expiry date of the medication: .....

Note: if you can't provide this information now we will need to know the expiry date when the medication is given to the school. All medication must be in original packaging, showing script details including required dosage and dispening details.

Special storage requirements if any eg in refrigerator: .....

.....

Special instructions for administering the prescribed medication/s eg must be taken with food or with a glass of water:

.....

Through information you have obtained from your doctor or got yourself, are you aware of any likely side effects from the prescribed medication?

Yes ☐ No ☐ If Yes, Please provide more information:

.....

If your child administers his or her own medication at home, do you request that he or she self administers this medication at school?

Yes ☐ No ☐

Note: the Principal needs to approve a decision for a student to self administer.

If yes, please describe what support your child needs to administer the medication in a non emergency situation at school. You may like to include information about how you support your child at home to administer their medication.

.....

.....

Secure delivery of prescribed medication is important for the safety of your child as well as for the safety of other students in the school.

Please name the person who will carry the medication to school:

.....

Note: if you are unable to deliver the medication to school, it is advisable that you nominate a responsible person, who is not a school staff member, to transport the medication to the school.

For some medications and some students it can be appropriate for them to carry their own medication to and at school. For example, asthma reliever medication and pancreatic enzymes for cystic fibrosis. If your child is to carry their own medication we want to be able to support this and request some information so that we are well informed.
Note: The school may still need you to provide the school with an additional supply of the medication for storage in central location/s within the school and for use if your child needs the schools help.

Would you like the Principal to consider a request for your child to carry their medication?

Yes ☐ No ☐

Note: The Principal needs to approve a decision for a student to carry their own medication at school.

If yes, please describe where and how your child will carry this medication, for example, my child will carry it on their person in a medical pouch or bum bag.

.....

.....

.....

Note: Your child's medication should be clearly labelled with their name..

Schedule for the Administration of Prescribed Medication

Days Required	Medication Name	Dosage	Time to be administered
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			