Silver Tree
STEINER SCHOOL

HEALTH CARE MANAGEMENT PLAN

This form is to be used when requesting the administration of long-term medication and planning for student health care needs.

Student Name: **DOB:** **Class:**

Section A – Health Care Planning – to be completed by the parent/guardian

Name of your child's health condition or need:

Daily Management Planning (if required). This may include a list of strategies that would minimise the risk of exposure to known allergens in the case of allergy or anaphylaxis:

Section B – Emergency Response Plan (if required) – To be completed by parent/guardian and/or medical practitioner

For allergy and anaphylaxis, please complete the appropriate ASCIA Action Plan and submit with this form instead.

For Asthma, please complete an Asthma Action Plan and submit with this form instead. Forms can be accessed on the school website.

Section C – Staff Training Requirements

Is specific training for staff required to manage your child's condition or needs? (You may like to discuss with the Head of School or a medical practitioner).

A. For daily management? Yes ☐ No ☐ If yes, please describe:

B. In an emergency? Yes ☐ No ☐ if yes, please describe:

Section D – Medication Instructions (Note: Medication must be provided by parent/guardian)

	Medication 1		Medication 2		Medication 3	
Name of medication						
Expiry date						
Dose/frequency – (may be as per the pharmacist's label)						
Duration (dates)	From: To:		From: To:		From: To:	
Route of administration						
Administration Tick appropriate box	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage instructions Tick appropriate box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

Section E –Authority to Act.

I/we authorise school staff to provide health care support for my/our child in accordance with the above plan and/or the attached plan from a medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent/Guardian: Date:	Medical Practitioner: If required (At the Head of School's discretion) Date:

Review Date:

OFFICE USE ONLY

Date received:

Is specific staff training required? **Yes** ☐ **No** ☐ Type of training:

Training service provider:

Name of person/s to be trained:

Date of training:

To be filed with Student Record and as per Student Health Care Policy

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Student Name			**DOB**	
Class			***Please attach this form to applicable Health Care Management Plan or Administration of Medication form***	
Date	**Time**	**Support/Medication**	**Staff Member**	**Signature/Initials**

RECORD OF HEALTH CARE SUPPORT/ADMINISTRATION OF MEDICATION

Student Name			**DOB**	
Class		***Please attach this form to applicable Health Care Management Plan or Administration of Medication form***		
Date	**Time**	**Support/Medication**	**Staff Member**	**Signature/Initials**