FORM 2 - GENERIC HEALTH CARE MANAGEMENT & EMERGENCY RESPONSE PLAN (LONG TERM)

*Note: this form is to be used when a parent/carer requests school staff to administer medication to their child on a **long-term basis** (more than two weeks). Short-term medication requires a Form 3 to be completed.*

Name:	**Date of birth:**	**Year:**	☐ Day student ☐ Boarding student

Section A: Student health care planning *Note: to be completed by parent/carer*

Name of your child's health condition(s) or need(s):
Daily management planning (if required):

Section B: Emergency response plan *Note: to be completed by parent/carer or medical practitioner*

Section C: Staff training requirements *You may need to discuss with the principal or a medical practitioner*

Is specific training for staff required to manage your child's condition or needs:

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 parents/carers AND daily medication must be Webster packed*

	Medication 1	**Medication 2**	**Medication 3**
Name of medication			
Expiry date			
Dose			
Time(s) & frequency			
Duration *(dates medication is required)*	Start: End:	Start: End:	Start: End:
Route of administration	☐ Oral ☐ Injection ☐ Topical ☐ Other:	☐ Oral ☐ Injection ☐ Topical ☐ Other:	☐ Oral ☐ Injection ☐ Topical ☐ Other:
Administration	☐ By self ☐ Requires assistance	☐ By self ☐ Requires assistance	☐ By self ☐ Requires assistance

Storage instructions	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*
Storage conditions	☐ Keep out of sunlight ☐ Refrigerate ☐ Other:	☐ Keep out of sunlight ☐ Refrigerate ☐ Other:	☐ Keep out of sunlight ☐ Refrigerate ☐ 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.

Name of parent/carer:

Signature of parent/carer:

Date:

Name of medical practitioner: *Leave blank if not required*

Medical practice details:

Signature of medical practitioner:

Date:

Review date:

When complete, please attach the student health care summary form to the front of this document and return to your child's school.

OFFICE USE ONLY	
Date received:	Date uploaded on SIS:
Medication storage location:	
Is specific staff training required? ☐ Yes ☐ No	
Type of training:	
Training service provider:	
Name of person/s to be trained:	
Date of training:	