FORM 9 – PERSONAL CARE ACTIVITIES

Note: Where a medical practitioner provides a written plan for staff to follow, this form may not need to be completed. A separate Form 9 should be completed for each personal care activity.

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

Section A: Planning to support student who requires assistance with personal care activities

To be completed by parent/carer or the relevant medical practitioner

Type of activity requiring support:

Section B: Instructions

Please list steps involved to manage the activity. For example: Catheterisation – Care of in-dwelling catheter

Step 1	
Step 2	
Step 3	
Step 4	

Section C: Emergency response plan (if required)

Section D: Medication instructions (if required)

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) or 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
This form authorises school staff to follow my/our advice and/or that of our 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:	