



# PORT LINCOLN HIGH SCHOOL

## STUDENT HEALTH SUPPORT & MEDICATION MANAGEMENT POLICY

Student Name ..... Date of Birth .....

The safety, well-being and health of your child is vitally important to us. We aim to assist the student, parents/careproviders in all matters, but can only do so with your full cooperation. Please complete the following information. The teacher will arrange medical attention for any student when this is necessary.

<b>MEDICAL CONDITION(S)</b>			
Does your student have any medical condition or health problem that might affect him/her? Circle your answer please (eg vision or hearing impairment, convulsions or seizures, asthma or other chest or breathing problems, medication, diabetes)			
In the classroom		<b>Yes/No</b>	
During physical education or sports activities		<b>Yes/No</b>	
During camps, aquatics, other activities		<b>Yes/No</b>	
Date of last Tetanus Injection .....			
What is the nature of condition?			
How could it affect the student?			
What treatment is required?			
<b>MEDICAL EMERGENCIES</b>			
Are you aware of any possible medical emergencies which could affect this student?			<b>Yes/No</b>
If you have answered "Yes" please complete the following:			
What is the emergency?			
How will the school recognise the emergency?			
How could it be prevented or avoided?			
How should it be treated at school?			
<b>MEDICATIONS</b> - Is it necessary for your student to take medication daily as part of the treatment for the medical condition? <b>Yes/No</b>			
If you have answered "Yes" please give details below of medication.			
Name of Medication(s)	Dose	When to be taken	Possible Side-effects
<b>SPECIAL AIDS</b> Does your student need to use any special aids (eg, glasses, hearing aids, callipers, etc)			

If you have answered "Yes" to any of the above questions, it would be greatly assist the school if you would supply a statement from your Doctor detailing any treatments, especially for any emergency which may arise.

**PARENT/CAREPROVIDER'S SIGNATURE** ..... **DATE** ...../...../.....



# PORT LINCOLN HIGH SCHOOL

## STUDENT MEDICAL and HEALTH INFORMATION

To the DOCTOR of ..... Date of Birth .....

ADDRESS .....

DEAR DOCTOR

This school would appreciate receiving relevant medical information about the above named student so that school staff can manage him/her appropriately:

- At school
- During physical education or sporting activities
- During excursions, camps, aquatics or other out of school activities

This matter has been discussed with the parents/careproviders who have agreed to the release of any relevant information.

PRINCIPAL ..... DATE .....

What is the nature of any medical condition which may affect this student during school activities?	
What special considerations are involved for management of this condition? (NB the need for medication or restrictions of any activities, etc)	
What emergency situation, if any, could arise as a result of the medical condition?	
What emergency action do you recommend for such an emergency?	
Any additional comments or information which you consider to be relevant:	

Doctor's Signature .....

Date .....

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### AUTHORISATION BY PARENT/CAREPROVIDER

Please provide any relevant information for school records as requested above.

PARENT/CAREPROVIDER'S SIGNATURE ..... DATE .....