ST JOSEPH'S GENERIC HEALTH CARE MANAGEMENT & EMERGENCY RESPONSE PLAN

NAME: **DATE OF BIRTH:** **YEAR:**

1. Health condition (Name of your child's health condition or need) –

Daily management planning (if required):

2. Emergency Response Plan (if required) – To be completed by parent/caregiver and/or medical practitioner

3. Staff Training Requirements

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

A. For Daily management? Yes ☐ No ☐ If yes, please give details:

B. In an emergency? Yes ☐ No ☐ If yes, please give details:

3. Medication instructions (Note: Medications to be provided by the parent/caregiver)

	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	☐ ☐ ☐ ☐ ☐

4 Authority to Act.	
This general health care management and emergency response plan authorises the 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 child's health care requirements.	
Parent: Date:	Medical Practitioner(if required): Date:
Review date:	Correction Factor
OFFICE USE ONLY	
Date received:	Date uploaded to SEQTA:
Is specific staff training required? YES ☐ NO ☐	Type of training
Training service provider:	
Name of person's to be trained:	Date of training:
When completed, add to student file.	