

- This record is to be completed for any significant medical condition that could lead to a medical emergency. It is to be completed by parents/carers in consultation with their child's doctor (Specialist or General Medical Practitioner)
- A Treatment Plan may be attached if developed by the Specialist or General Medical Practitioner provided this is indicated at Section B and the plan is signed off by the parent/carer at Sections C & D
- Parents/carers should inform the school immediately if there are any changes to the plan and provide a reviewed plan
- Copies of the plan are kept on the student file, in the first aid room and provided to the First Aid Officer for any offsite excursion

The Directorate collects the information contained in this form to provide or arrange first aid and other medical treatments for students. The information collected will be held at your child's school and will be made available to staff of the school and to medical or paramedical staff in the case of an accident or emergency. The information contained in the form is personal information and it will be stored, used and disclosed in accordance with the requirements of the *Privacy Act 1998(Cwth)*. Parents/carers note that in the absence of an Emergency Treatment Plan only standard First Aid will be administered.

**Section A. Personal Details**

Student's name:			<b>Insert student's photo here</b>
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth:	Year/Class	
Emergency contacts (e.g. parent, carer):			
Name 1		Relationship	
Telephone No		Work No/Mobile	
Name 2		Relationship	
Telephone No		Work No/Mobile	
Doctor:		Telephone No:	
Medications:			

**Section B. Emergency Treatment Plan developed by Specialist or General Medical Practitioner**

Attached  Yes (Complete Section C and D only)  No (Complete Section B,C & D below)

**Emergency Treatment Plan for :** \_\_\_\_\_ (Title of significant medical condition)

Step 1:
Step 2:

Step 3:
Step 4:
Step 5:
Step 6:
Step 7:

**Section C. Individual Routine Support Needs**

Is this student able to self manage their own care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, detail assistance requested from staff to support safety		
Please detail the students usual signs in case of an emergency and the action they typically take ( If not outlined on attached plan)		
Record regular procedures that will be occurring at school and any other relevant information.		

**Section D. Consent**

I verify that I have read/developed the preferred Emergency Treatment Plan above/attached (delete as appropriate) and agree with its implementation.

Signature of Doctor:		Date	Date of Plan					
Signature of Parent/Carer:		Date	Review	N/A	1	2	3	4
				<input type="checkbox"/>				

- a)** I/We (parent/carer) give permission for my/our child (name):
- to be treated in an emergency by staff at the school using this Emergency Treatment Plan, if in their judgement it is required.
  - to be identified by a Student Medical Alert poster including a photograph of my child and personal information which is to be displayed in the school’s first aid and medical treatment room/s, staff room/s and other locations as considered necessary. These locations will be discussed with the parents/carers prior to action.
- b)** As a parent/carer I will notify you immediately of any change to this plan and provide a reviewed plan to ensure the plan is current.

Signed: \_\_\_\_\_ Date