# STUDENT HEALTH MAINTENANCE ACTION PLAN

Please complete this form **ONLY** if your child has a health problem which the school needs to be aware of.

**Name:** _____ **Home Phone:** _____

**Address:** **Mobile:**

**Emergency Contact Person (in case parents are unable to be contacted):**

**Name:** **Relationship to child:** **Phone:**

**Doctor's Name:** **Phone:**

**HEALTH PROBLEM:** _____

**How it affects child**: severe / mild / other (please describe in detail)
(attach separate page if necessary)

**ACTION PLAN:**
**Please indicate what medications your child regularly takes:**
(If the medication is to be administered at school, please complete the authorisation form below.)

**How does the medication affect your child?**
**(i.e. drowsy, thirsty, excited)**

**Any other information about your child's health that the school needs to be aware of:**

Signed: ..... (parent/caregiver) Date: .....

## Administration of Prescribed Medication

Authorisation / Disclaimer

I / We, ..... caregivers of .....

wish for him / her to receive medication at school on a regular basis.

Name of Medication: .....

Dosage:..... Time(s) of day medication to be taken:.....

- I am aware that the Board of Trustees and it's employees will not accept any responsibility for accidental or incorrect dosage, the failure by a child to take medication when prescribed, or claims for any long-term side effects.
- I am aware that it is my child's responsibility to arrive at the office at the appropriate time to receive the medication.
- In the case of asthma: My child is capable of using the asthma inhaler on his/her own and will carry it him/herself. Yes / No / Not applicable
- I have read the Board's current policy on medication and confirm that I understand it.

Signed:..... Date:.....