



### Office use only

Medical conditions: _____	Academic year	7	8	9	10	11	12
_____	Calendar year						
_____	Form/class						

Office use: Student's name: \_\_\_\_\_

UMRN: \_\_\_\_\_

Retain until: \_\_\_\_\_

### Particulars of student

Surname: \_\_\_\_\_ First name: \_\_\_\_\_

Preferred name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender:  Male  Female

Current address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Student's mobile: \_\_\_\_\_

Current school: \_\_\_\_\_ Last school attended: \_\_\_\_\_

Country of birth: \_\_\_\_\_

Main language spoken at home: \_\_\_\_\_ Interpreter required:  Yes  No

Student of Aboriginal origin?  Yes  No

### Parent/guardian contact

Surname: \_\_\_\_\_ First name: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Mobile: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Student's brothers and sisters:

1. Full name: \_\_\_\_\_ Year of birth: \_\_\_\_\_

2. Full name: \_\_\_\_\_ Year of birth: \_\_\_\_\_

3. Full name: \_\_\_\_\_ Year of birth: \_\_\_\_\_

4. Full name: \_\_\_\_\_ Year of birth: \_\_\_\_\_

5. Full name: \_\_\_\_\_ Year of birth: \_\_\_\_\_

**The Health Centre at school does not stock or routinely give out medicines for headaches or other pain relief. Parents are advised to supply medicines for their child if needed.**

The School Dental Service (SDS) provides free dental health checkups to students attending a Department of Education recognised school from 5 to 16 years of age or to Year 11, whichever comes first. For more information please call 9313 0555 or visit [www.dental.wa.gov.au](http://www.dental.wa.gov.au)

If you would like assistance completing this form, please contact the Community Health Nurse at your child's school.

# High School Health Record

If your child has a health issue that may require support at school, a parent/guardian is required to complete a health care plan which is available from the school administration office. This will inform and prepare the school staff to better manage health care needs and or respond to health emergencies during school hours.

## Student health status

Tick current health issues

Office use only:

Anaphylaxis risk	
Asthma	
Allergies	
Diabetes	
Diagnosed migraine or other headaches	
Epilepsy	
Hearing impairment	
Mental health and wellbeing concerns	
Visual impairment	
Learning difficulties	
Other condition/s	

Please note any other information which would be helpful for the Community Health Nurse:

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**The information on this form remains confidential and is used only by authorised Health Service staff. Consent to provide health care and/or to share personal information will be sought from parent, guardian or student as appropriate.**

This form was completed by:

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 20\_\_

## Office use only:

Date	Acuity level	

**Confidential Record**



