Hendon Primary School OSHC Enrolment Form

Medical and Health Information (Confidential)

This information is confidential and will be available only to supervising staff and emergency medical personnel

One form per child

Family Name	Child's Name	Date of Birth

Medic Alert Number (if relevant)_____ Review Date _____

Health Support

✵ **Does your child have a health care need that could affect their safety at Out of school Hours Care?**

☐ No

☐ Yes **If YES** please tick the boxes below that show your child's health care needs.

	✓		✓
Asthma		Incontinence	
Is your child under a health care plan for Asthma?		Joint Disorder (eg arthritis)	
Epilepsy		Ear Disorder (eg arthritis)	
Heart Disorder		Hearing Impairment	
Vision Impairment		Communication difficulties	
Seizures/convulsions		Skin condition (eg dermatitis)	
Allergies (eg bees, peanuts dairy)		Swallowing/choking difficulties	
Diabetes		Other (please give details)	

Health Care Plan

✵ Out of School Hours Care staff need a written health care plan from your child's doctor/treating health professional to plan for any special health needs. **Have you attached the health care information from your child's docor/treating health professional?**

☐ If No, staff will provide standard supervision for safety & first aid

☐ **If YES** write down what you have attached (eg asthma care plan; details about ear care)

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Medication

✵ Does your child have any routine health care needs (eg: medication

☐ No

☐ Yes please attach a medication plan from your doctor or treating health care professional.

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Doctor's Name	**Clinic Name**
Address	**Phone Number**

✵ Are there any special dietary requirements relation to your child?

☐ No

☐ Yes please give details

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✵ Does your child need special aids or equipment (eg. Glasses, hearing aids, callipers

☐ No

☐ Yes please give details

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1. All medication must be supplied in the original container with the pharmacy label and the child's name clearly marked o the container.
2. A permission to administer medication form must be signed by the parent/doctor before medication can be administered by OSHC staff or self-administered by a child over 8 years of age.

Parent/Guardian/Approved Person

Signature_____ **Date**_____