

# General health information

for education, child/care and community support services

## CONFIDENTIAL

To be completed by the TREATING HEALTH PROFESSIONAL (general practitioner, psychiatrist, psychologist) and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT for a person requiring additional care/supervision related to his or her general mental and/or physical health and well-being. Other proformas are available for more specific health care plans.

Name of child/student/client \_\_\_\_\_ Date of birth \_\_\_\_\_  
Family name (please print) First name (please print)

MedicAlert Number (if relevant) \_\_\_\_\_ Date for next review \_\_\_\_\_

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### Description of the condition

It is not necessary to provide a full medical history. Staff members only need to know information relevant to the person's attendance, learning and well-being in education, childcare or community support services.

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### Implications for education and care settings

Please include only information that supervising staff need to teach and care for this person, for example:

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|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Impact on capacity to attend and participate in routine learning activities | <input type="checkbox"/> Need for additional emotional support                |
| <input type="checkbox"/> Limitations on physical activity                                            | <input type="checkbox"/> Behaviour management plan                            |
| <input type="checkbox"/> Need for rest/privacy                                                       | <input type="checkbox"/> Considerations for camps, excursions, social outings |

Please provide details \_\_\_\_\_

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**Description of any warning signs, triggers or circumstances and recommended responses.**

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**Additional information**

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**This plan has been developed for the following services/settings:**

<input type="checkbox"/> School/education	<input type="checkbox"/> Outings/camps/holidays/aquatics
<input type="checkbox"/> Childcare	<input type="checkbox"/> Work
<input type="checkbox"/> Respite/accommodation	<input type="checkbox"/> Home
<input type="checkbox"/> Transport	<input type="checkbox"/> Other (please specify) _____

**AUTHORISATION AND RELEASE**

Health professional \_\_\_\_\_ Professional role \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I have read, understood and agreed with this plan and any attachments indicated above.  
I approve the release of this information to supervising staff and emergency medical personnel.**

Parent/guardian  
or adult student/client \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Family name (please print) First name (please print)