FORM 10 - EMERGENCY RESPONSE PLAN FOR A STUDENT WITH SPECIAL NEEDS

This form is to be used for specifying the emergency action plan required for special needs students with multiple conditions

Student Details		
School:	Year: Form:	Insert Photo Here
Name:	Date Of Birth:	
Medical Practitioner:	Parent/Carer:	
Medical Practice Telephone:	Parent/Carer Telephone:	
Specialist:	Parent Carer Address:	
Specialist Telephone No:	Medicare Card No:	
Specialist Centre/Hospital:	Health Care Card: Yes ☐ No ☐	
Specialist Centre/Hospital Address:	Health Care Card No:	

Section A – Health Conditions/Needs: Diagnosis(S): List Below

	Medic Alert		**Medic Alert**		**Medic Alert**
	Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐
	Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐

Section B – Daily Health Care Routines

Routine	**Required**	**Comments**
Communication	**Yes** ☐ **No** ☐	
Diet Or Feeding	**Yes** ☐ **No** ☐	
Toileting	**Yes** ☐ **No** ☐	
Transportation	**Yes** ☐ **No** ☐	
Classroom Activities	**Yes** ☐ **No** ☐	
Behaviour	**Yes** ☐ **No** ☐	
Other	**Yes** ☐ **No** ☐	

Section C –Medical History

Date: / /

NAME: SCHOOL: DOB:

Section D – Medication Records - To be completed in collaboration with the principal and parent/carer

Medication E.g., Insulin	Expiry Date	Dose/ Frequency	Route Of Administration	Name Of Administrator	Storage Place	
					Stored at school **Refrigerate** **Keep out of sunlight**	☐ ☐ ☐
					Stored at school **Refrigerate** **Keep out of sunlight**	☐ ☐ ☐
					Stored at school **Refrigerate** **Keep out of sunlight**	☐ ☐ ☐
					Stored at school **Refrigerate** **Keep out of sunlight**	☐ ☐ ☐

Section E: Emergency Action Plan(S)
(Please list for each relevant diagnosis and attach relevant plan(s)

Section F – Equipment

Mobility:

Health Care Supplies:

Assisted Technology: E.G. Walker, Wheel chair, Communication Device, Oxygen Tank

Other Relevant Information: