

FORM 9 – PERSONAL CARE ACTIVITIES FORM

Note: A separate Form 9 should be completed for each personal care activity

Name: _____ Date of Birth: _____ Year: _____ Form: _____ Teacher: _____

Section A: Planning to support students who require assistance with personal care activities.

To be completed by parent or the relevant medical practitioner and returned to the school

Type of activity requiring support: _____

Section B: Instructions:

Please list tasks or steps involved to manage the activity. For example: Catheterisation – Care of in-dwelling catheter

Step 1

Step 2

Step 3

Section C – Emergency Response Plan (if required):

Section D – Medication (If applicable) (Note: If required, medication must be provided by parents)

Name of medication			
Expiry date			
Dose/Frequency – (May be as per the pharmacist's label)			
Duration (Dates)	From : To:	From : To:	From : To:
Route of administration			
Administration Tick appropriate box	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>
Storage instructions Tick appropriate box(es)	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>

Section E – Authority to act

This form authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent:	Medical practitioner (if required):
Date:	Date:
Review date:	Form 9 page 1 of 2

Note: Where a medical practitioner provides a written plan for staff to follow, this form may not need to be completed.

Name: _____ Date of birth: _____ Year: _____ Form: _____ Teacher: _____

OFFICE USE ONLY

Is support to be provided by a member of staff? Yes No If yes, name(s) of authorised staff: _____

Is specific staff training required? Yes No Date of training: / / Date of retraining: / /

Type of training: _____

Training providers: _____

Name of person(s) to be trained:

Actions taken:

When completed please attach the *Form 1: Student Health Care Summary* to the front of this document.