Northern Territory Government

DEPARTMENT OF **EDUCATION**

Student's Health Care Plan

Copy scanned to Nurse ☐
Copy placed on SRF ☐

Name			Date
DOB	Age	M ☐ F ☐	Class Teacher (Primary) Or Home Teacher (Middle or Secondary)
School			Year Level
Parents /Guardians		Address	
Phone Contact		Health Care Team	

BACKGROUND (What illness, disease or condition does the student suffer from?)
ASSESSMENT SUMMARY (How long diagnosed/ ongoing treatment/ upcoming surgeries/ symptoms of illness?)
AREAS OF CONCERN (What makes it worse? When does it happen?)
ACTIONS TO BE TAKEN (First Aid requirements)
RECOMMENDATIONS (How can we as a school support your students medical condition?)

Signature of Parent / Guardian	Date
Signature of Principal	Date
Signature of Medication Administration Officer	Date