Government of **Western Australia**
Department of **Health**

# High School Health Record

**Office use only**

| Medical conditions: | Academic year | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|
| | Calendar year | | | | | | |
| | Form/class | | | | | | |

## Particulars of student

Surname: ________ First name: ________

Preferred name: ________

Date of birth: ________ Gender: ☐ Male ☐ Female

Current address: ________

________ Postcode: ________

Student's mobile: ________

Current school: ________ Last school attended: ________

Country of birth: ________

Main language spoken at home: ________ Interpreter required: ☐ Yes ☐ No

Student of Aboriginal origin? ☐ Yes ☐ No

## Parent/guardian contact

Surname: ________ First name: ________

Relationship to student: ________

Mobile: ________ Home: ________ Work: ________

Student's brothers and sisters:

1. Full name: ________ Year of birth: ________
2. Full name: ________ Year of birth: ________
3. Full name: ________ Year of birth: ________
4. Full name: ________ Year of birth: ________
5. Full name: ________ Year of birth: ________

**The Health Centre at school does not stock or routinely give out medicines for headaches or other pain relief. Parents are advised to supply medicines for their child if needed.**

The School Dental Service (SDS) provides free dental health checkups to students attending a Department of Education recognised school from 5 to 16 years of age or to Year 11, which ever comes first. For more information please call 9313 0555 or visit www.dental.wa.gov.au

If you would like assistance completing this form, please contact the Community Health Nurse at your child's school.

**Office use:** Student's name: ________ UMRN: ________ Retain until: ________

# High School Health Record

If your child has a health issue that may require support at school, a parent/guardian is required to complete a health care plan which is available from the school administration office. This will inform and prepare the school staff to better manage health care needs and or respond to health emergencies during school hours.

**Student health status**

Tick current health issues

| | Tick current health issues | Office use only: |
|---|---|---|
| | Anaphylaxis risk | |
| | Asthma | |
| | Allergies | |
| | Diabetes | |
| | Diagnosed migraine or other headaches | |
| | Epilepsy | |
| | Hearing impairment | |
| | Mental health and wellbeing concerns | |
| | Visual impairment | |
| | Learning difficulties | |
| | Other condition/s | |

Please note any other information which would be helpful for the Community Health Nurse:

________________________________________

________________________________________

________________________________________

________________________________________

**The information on this form remains confidential and is used only by authorised Health Service staff. Consent to provide health care and/or to share personal information will be sought from parent, guardian or student as appropriate.**

This form was completed by:

Name:____________________ Relationship to student:____________________

Signed:____________________________ Date:_____/_____/ 20_____

**Office use only:**

| Date | Acuity level | |
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**Confidential Record**

| Date and time | Progress notes | Name, signature and designation |
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| Date and time | Progress notes | Name, signature and designation |
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