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						

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

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.

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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

		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:

_____

_____

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_____

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	

Confidential Record

Date and time	Progress notes	Name, signature and designation

Date and time	Progress notes	Name, signature and designation