NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF EDUCATION

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Student Health Care Plan

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
ASSESSMENT SUMMARY
AREAS OF CONCERN
ACTIONS TO BE TAKEN
RECOMMENDATIONS

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