Aboriginal & Islander Independent Community School Inc.
Education in Harmony
"Our Culture, Our Children, Our Future"

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Dear Parents, Care Providers and Friends

The Murri School is offering many services to our children and parents to help them manage any health issue/s and provide information and advice about healthy behaviours.

Please indicate with a tick the services you give permission for:

TICK BELOW:

☐	link children and families to community-based health and wellbeing services
☐	the opportunity to have a health assessment
☐	**administer:** Ventolin (even for a non-asthmatic but a first event has occurred) Epipen (this could be for existing students with anaphylaxis or a new event) -Paracetamol -Nurofen -Antihistamines (used for allergies) -antacids (used for mild stomach upsets) -lotions and creams (this would cover a number of different items) -cold and flu tablets
☐	prescribed medication that is to be taken at school, the school nurse or school personnel designated by the school nurse will administer this medication

Child's name: _____

Parent signature: _____

Date: _____

MURRI SCHOOL HEALTH CARE PATHWAY CONSENT

Student Details

Full Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Consent:

☐	I give permission for the Clinic Staff to share my child's health information with other stakeholders/services who are involved with my child's Health Care. This includes the National, State and Territory Recall and Reminder Systems, allied health providers, medical specialists (including paediatrician), and the Murri School Nurse.
☐	I give permission for the Murri school health care pathway coordinator to liaise with the health clinic to arrange and review appointments, check when my child is due for annual health check.
☐	I give permission for my child's teacher(s) and clinic staff to communicate about my child's health concerns and needs where relevant to education needs (e.g. referrals from teachers to GPs and summary of health checks from GPs to teachers).
☐	I give consent for clinic staff to gather information from Medicare for eligibility of services (e.g. annual health check) for my child and communicate this with the Murri school health care pathway coordinator.
☐	I give permission for clinic staff to provide audiology reports and details regarding my child's hearing and ear health to the Advisory Visiting Teacher-Hearing Impairment. This information will be used for the sole purpose of providing educational support to those children diagnosed with hearing loss.
☐	I give permission for my child to be referred to and attend allied health consultations at the school. E.g. Speech Pathology, Occupational Therapy, Psychology, Optometry, Audiology.
☐	I give permission for the allied health professionals to liaise with and discuss my child's needs with the school in relation to their schooling only. This information is solely to assist the school in providing additional schooling support if needed.
☐	I give permission for my child to participate in relevant health promotion activities provided by the School Nurse *i.e. Head Lice Program, Healthy Teeth Program, Nutrition, Health Check Days/Health Expos & Sex Ed*

Opt out procedure

Should you wish to withdraw this consent at any given time; written notification is required by the parent/guardian (only) of the child. Should you have any questions prior to signing the consent for your child (ren); please do not hesitate to contact us.

GP clinic:

I nominate the following medical service/clinic/GP to provide health care for my child:
Health Service: _____ (*ATSICHS, Kambu, Inala Indigenous Health, Other*)
Clinic Location: _____ (*Eg. Woolloongabba, Northgate, Loganlea, Ipswich, Woodridge, Browns Plains, Goodna, Inala, Capalaba, Wynnum, Stradbroke Island*)
Preferred GP (if any): _____

Health and other information

Home Address: _____
Contact Number: _____ Gender: _____
Siblings Names and Ages _____

_____

Medicare Number: _____ Ref: (___) Exp Date ___ / ___
HCC/PENS: _____ Exp Date: ___ / ___ /___
Medical Conditions (asthma, ADHD, autism, anxiety, depression etc): _____

_____

Current Medications: _____
Allergies: _____

In signing below, I nominate the GP clinic listed above and consent to all the points that I have ticked on the previous page.

Parent/Guardian Signature: _____ ___
Date: ____ / ____ / ____