HEALTH & MEDICAL FORM

Child's Full Name	DOB	PCYC Membership Number

Parent/Guardian & Emergency Contact Information

Name & Relationship	
Address	
Phone	
Email	

Second Emergency Contact

Name & Relationship	
Phone	

HEALTH, MEDICAL CONDITIONS & COMPLEX BEHAVIOUR

1. HAS YOUR CHILD BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS?

- [ ] Epilepsy
- [ ] Anaphylaxis – Please provide ASCIA Action Plan for Anaphylaxis
- [ ] Asthma – Please provide Asthma Action Plan
- [ ] Sensory deficits – i.e. visually and/or hearing impaired
- [ ] Language delay – i.e. expressive or receptive communication delay

2. HAS YOUR CHILD BEEN DIAGNOSED AND/OR KNOWN TO DISPLAY ANY OF THE FOLLOWING BEHAVIORS?

- [ ] Autism spectrum disorder
- [ ] Attention deficit order
- [ ] Challenging behaviors
- [ ] Physical and/or verbal aggression towards others
- [ ] Absconding
- [ ] Sexually abusive behaviors
- [ ] Self-harm
- [ ] Sensory aversion – i.e., hypersensitivity, loud sounds etc.

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3. REGARDING ANY CHALLENGING BEHAVIOR PLEASE FILL OUT THE TABLE BELOW TO HELP BETTER UNDERSTAND HOW TO SUPPORT YOUR CHILD?

Identified behaviour e.g. physical aggression	Warning Signs e.g starts pacing the room	Known triggers e.g opposition to any request	Strategies to manage behavior

4. SPECIAL REQUIREMENTS & DIETARY NEEDS

Please identify any special needs or requirements not listed above (eg. diet, wheelchair access etc.)

ADMINISTRATION OF MEDICATION

If medication needs to be administered during the program, please complete the following section:

Name of Medication	Expiry Date	Storage Requirements

Dosage	Method of Self-administration	Frequency

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Are there any circumstances that need to be considered in the administration/storage or delivery of the medication?

I authorise the staff at PCYC ....

to supervise the self-administration of the medication(s)as recorded on the table.

OFFICE USE ONLY

Prior to administering any prescribed medication to a child, the following questions must be answered. In the event the answer to any of the below questions are 'no', a service will refuse self-administration.

Is the medication in its original container or as dispensed by a pharmacist?	Y ☐	N ☒	
Is the dispensing label attached to the medication/container?	Y ☐	N ☒	
Is the prescribing doctor's information on the label?	Y ☐	N ☒	
Does the name on the dispensing label match that of the child above?	Y ☐	N ☒	
Does the expiry date on the medication match that on the box?	Y ☐	N ☒	
Is there an Action Plan OR Medical Alert sheet for this child?	Y ☐	N ☒	N/A ☐

BOOKING DETAILS

Date	Name	Last administered (if applicable)	To be administered (if applicable)	Staff supervising self-administration	Dosage	Time	Method	Parent/ guardian signature (end of day)