

FORM 9 – ACTIVITY OF DAILY LIVING PLANNING FORM

Note: A separate Form 9 should be completed for each activity of daily living

Name: _____ Date of Birth: _____ Year: _____ Form: _____ Teacher: _____

Section A: Planning to support students who require assistance with Activities of Daily Living

To be completed by parent or the relevant medical practitioner and returned to the school

Type of activity of daily living requiring support: _____

Section B: Instructions:

Please list tasks or steps involved to manage the activity. For example: Catheterisation – Care of in-dwelling catheter

Step 1

Step 2

Step 3

Section C – Emergency Response Plan (if required):

Section D – Support/Training Requirements

Can this activity of daily living be supported by a trained education assistant? Yes No

If no: please specify what additional support is required.

Can this activity of daily living be supported by other nominated and trained staff? Yes No If yes, please specify:

Name Of Medical Practitioner: _____ Signature: _____

Name Of Medical Practice/Hospital: _____ Date: _____

Section E – Medication (If applicable) (Note: If required, medication must be provided by parents/carers)

Name Of Medication			
Expiry Date			
Dose/Frequency – (May be as per the pharmacist's label)			
Duration (Dates)	From : To:	From : To:	From : To:
Route Of Administration			
Administration Tick Appropriate Box	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>
Storage Instructions Tick Appropriate Box(es)	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>

Section F – Authority to Act

This form authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent/Carer: _____ Medical Practitioner (if required): _____

Date: _____ Date: _____

Review Date: _____ **Form 9 page 1 of 2**

Note: Where a doctor provides a written plan for staff to follow, this form may not need to be completed.

:
Name: _____ **Date of Birth:** _____ **Year:** _____ **Form:** _____ **Teacher:** _____

OFFICE USE ONLY

Is support to be provided by an education assistant? Yes No If yes, name(s) of authorised staff: _____

Is specific staff training required? Yes No Date of training: / / Date of retraining / /

Type of training: _____

Training providers: _____

Name of person(s) to be trained: _____

If medical practitioner has indicated additional support is required, please specify authorised staff: _____

Actions taken: _____

When completed please attach the *Student Health Care Summary* to the front of this document.