FORM 9 – ACTIVITY OF DAILY LIVING PLANNING FORM
Kalamunda PS ESC
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)

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 Requires assistance	☐ ☐		By self Requires assistance	☐ ☐		By self Requires assistance	☐ ☐
Storage Instructions Tick Appropriate Box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐		Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐		Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

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: Date:	Medical Practitioner (if required): 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.

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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.