FORM 9 – ACTIVITY OF DAILY LIVING PLANNING FORM

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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
<th>Year:</th>
<th>Form:</th>
<th>Teacher:</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Name Of Medical Practitioner:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________</td>
<td>_________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name Of Medical Practice/Hospital:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
<td>______________</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name Of Medication</th>
<th>Expiry Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dose/Frequency – (May be as per the pharmacist’s label)</th>
<th>From:</th>
<th>To:</th>
<th>From:</th>
<th>To:</th>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Route Of Administration</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Administration</th>
<th>Tick Appropriate Box</th>
<th>Storage Instructions</th>
<th>Tick Appropriate Box(es)</th>
</tr>
</thead>
<tbody>
<tr>
<td>By self</td>
<td>Requires assistance</td>
<td>Stored at school</td>
<td>Kept and managed by self</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keep out of sunlight</td>
<td>Refrigerate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

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<td></td>
<td></td>
<td>Other</td>
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</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Parent/Carer:</th>
<th>Medical Practitioner (if required):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Review Date:</td>
<td></td>
</tr>
</tbody>
</table>

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