# **Schoolcare Program**

Referral Form 2025

The Schoolcare Program (SCP) is a service provided by the Department of Education (the department) in partnership with the Royal Children’s Hospital (RCH).

Through the SCP the RCH provides Victorian government school staff with the skills and knowledge to appropriately support and care for students who have ongoing complex medical needs.

The SCP enables students with ongoing complex medical needs to have their daily medical needs met safely at school. The department, through your child’s school, collects relevant health information about your child through this referral process and determines if your child is eligible for support through the SCP. If eligible, this information is provided to the RCH to develop a child-specific care plan. SCP nurses will attend your child’s school and provide specialist training to nominated school staff. Once the nominated staff have successfully completed the training, they can then provide the interventional medical care and support to your child when they are at school, consistent with the care plan.

This program is available to students who would be unable to attend school without the procedure being performed by appropriately trained staff.

Further information about the SCP may be found in the [Schoolcare Program Guidelines](https://www.education.vic.gov.au/school/teachers/learningneeds/Pages/schoolcare-program.aspx): https://www.education.vic.gov.au/school/teachers/learningneeds/Pages/schoolcare-program.aspx

# Referral Timelines

**Existing SCP students:** For SCP staff to deliver relevant and appropriate training, the SCP Referral Form must be submitted each year to ensure an accurate profile of a student’s current medical needs is obtained. Referral forms should be submitted by **15 November** **2024** to assist the department with program delivery planning.

**New Referrals:** New referrals should be submitted **by 29 November** **2024** to assist with program delivery planning for the following year.

**Late Referrals:** Referrals can be received at any time during the year for students with deteriorating conditions or students transferring into or between government schools. Once all required documentation is received, training to support eligible students will be arranged as soon as possible. Referrals received in the second half of the year will be reviewed on a case-by-case basis in order to maintain the training schedule for existing referrals in place for the year.

If referrals are received after **1 July** and SCP training is required again for the following year, schools must still complete a new referral with updated staffing details and signed parent/carer consent.   Updated medical information is not required under these circumstances unless the student’s medical needs have changed.

# Parent/Carer Information

# Privacy Notice

The Department of Education (the department), which includes all Victorian government schools (schools), values your privacy and is committed to protecting information that schools collect.

All staff and all schools must comply with Victorian privacy law and applicable department and school-level privacy policies.

In schools, the collection and management of personal and health information of your child is governed by the Privacy and Data Protection Act 2014 (Vic) and Health Records Act 2001 (Vic) (collectively, **Victorian privacy law**).

This privacy/collection notice outlines how your child’s personal and health information will be collected and used upon referral by your child’s school to the SCP.

By providing your child’s personal and health information you agree to it being handled by the SCP team at the department and specialist team at the RCH in accordance with this Privacy Notice or where otherwise authorised or permitted by law.

All information will be handled in accordance with Victorian privacy law and the department’s policies regarding privacy and records.

**Collection and use of your child’s personal and health information**

Through the referral process, your child’s school will collect and use your child’s personal and health information and share this information with the RCH and the SCP team at the department to enable the SCP services to be delivered for your child.

The collection and use of your child’s information will enable the RCH and the SCP team at the department to:

* process the referral to the SCP
* assess the service your child requires
* develop a child-specific care plan for your child
* train school staff to support your child’s health needs while at school
* enable your child’s school, on behalf of the department, to fulfil various legal obligations, including its duty of care to your child.

**Handling and storage of information**

Your child’s personal and health information will be stored on EPIC Electronic Medical Record, located within Australia and the Schoolcare Program database, located within Australia. Access will be limited to:

* school staff at your child’s school who need to know as part of the referral to the SCP
* the RCH, approved health providers including Bendigo Health and Monash Children’s Hospital and those department staff administering the SCP that need to know in accordance with the department’s Privacy Policy
* those providing technical assistance for EPIC, the Schoolcare Program database or department systems.

The RCH must also comply with the *Health Records Act 2001* (Vic) when handling your child’s health information. Contact RCH directly for a copy of their privacy policy.

**Transfers to another Victorian government school**

Importantly, the department, including all Victorian government schools, is a single legal entity. This means that if your child transfers to another Victorian government school, your child’s personal and health information, including as collected through this process, will be transferred to that new school. This will occur even if your child is no longer receiving the SCP. This is because that information is required to enable the department, including the new school, to fulfil legal obligations, including its duty of care to your child.

**Further information**

For further information on this Notice, or to request access and correction of your child’s personal and health information, please email [schoolcare.program@education.vic.gov.au](mailto:schoolcare.program@education.vic.gov.au).

For more information regarding access to personal information or the department’s handling of personal information, please see the department’s privacy policy at: [Privacy and Information Sharing](https://www2.education.vic.gov.au/pal/privacy-information-sharing/policy)

Your consent on this form will remain current until the end of the 2025 school year. See the department’s [Privacy Policy](https://www2.education.vic.gov.au/pal/privacy-information-sharing/policy) for more information.

# Parent consent

# Part A To be completed by Parent/Carer

**Collecting personal and health information about your child**

**By providing consent you are consenting to your child’s school, on behalf of the department, collecting health information about your child so that they can be supported through the Schoolcare Program, as described in the ‘Schoolcare Program Referral Form’ above.**

I consent to my child’s school, on behalf of the department, referring my child to the Royal Children’s Hospital (RCH), for Schoolcare Program support.

I also specifically consent to:

* my child’s school, on behalf of the department, sharing my child’s health information with the Schoolcare Program staff
* my child’s medical practitioner/s nominated below providing health information to my child’s school and the RCH, through this process, to deliver the Schoolcare Program
* the school sharing my child’s health information with other school staff who ‘need to know’ to enable the school to:  
  (a) deliver the Schoolcare Program to my child  
  (b) fulfil the school’s legal obligations, including its duty of care to my child.

I understand I will be consulted and included in discussions relevant to the Schoolcare Program.

I also understand I am responsible for ensuring the school has the most up to date information regarding my child’s medical care needs and that the child-specific care plan reflects this.

**Training and procedures**

**By providing consent you are consenting to nurses from the Schoolcare Program delivering training to school staff, to enable the trained school staff to support your child at school in 2025**.

* I understand the Schoolcare Program will provide training to the nominated school staff regarding the medical support needs of my child
  + This may sometimes include Telehealth training (not recorded) e.g. for short updates/clarification following face-to-face training with the SCP nurse.
* I understand the trained school staff will then perform this procedure as set out in the child-specific care plan developed by the Schoolcare Program
* I understand my consent is valid until end of the 2025 school year.

|  |  |  |
| --- | --- | --- |
| Parent/Carer name |  | |
| Relationship to child |  | |
| Parent/Carer Email |  | |
| Signature |  | Date |

## 

# Student details

|  |  |  |  |
| --- | --- | --- | --- |
| Student First Name |  | Student Surname |  |
| Date of Birth |  | RCH UR number |  |
| Home Address |  | | |
| Home Phone |  | Mobile |  |
|  | | | |

## School details

## Part B To be completed by Principal

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| School Name |  | | | | | | School Ph. | | |
| School Address |  | | | | | | Campus | | |
| Student Disability ID |  | Year Level |  | | Is this student new to your school? | | | | Yes  No |
| Nominated School KEY Contact # 1 |  | | | | | Email: @education.vic.gov.au | | | |
| Nominated School Contact # 2 |  | | | | | Email: @education.vic.gov.au | | | |
| Names and email addresses of education support staff/teachers to be trained  \***SCP training is not available to school nurses.** Training for Registered Nurses should be sourced from a Registered Training Organisation (RTO) in accordance with Nurses’ professional standards and registration requirements. | First Name and Surname  Email address | | | Position | | Will the carer be performing the medical intervention/s at least once per week? | | Previous Schoolcare Program training for this student | |
| 1 | | |  | | Yes  No | | Yes  No | |
| @education.vic.gov.au | | |
| 2 | | |  | | Yes  No | | Yes  No | |
| @education.vic.gov.au | | |
| 3 | | |  | | Yes  No | | Yes  No | |
| @education.vic.gov.au | | |
| 4 | | |  | | Yes  No | | Yes  No | |
| @education.vic.gov.au | | |
| Preferred training days | Monday  Tuesday  Wednesday  Thursday  Friday | | | | | | | | |
| Impact of medical condition on student’s functioning at school |  | | | | | | | | |
| Principal’s name and signature | I verify all school details in Part B of this Schoolcare Program referral.  Name: Signed: | | | | | | | | |
| Referral checklist | **It is essential that all necessary documentation is included with the application**  **Part A** – Parent/carer consent and student details  **Part B** – School details including principal’s signature  **Part C** – Medical information  **Part C –** Current Epilepsy Foundation management and/or emergency medication management  plans where applicable | | | | | | | | |

**Schools should email completed referral forms to:**

[schoolcare.program@education.vic.gov.au](mailto:schoolcare.program@edumail.vic.gov.au)

Medical information

## Part C To be completed by parent/carer and medical specialist/practitioner

The details below should be provided by parent/carer(s) in conjunction with the child’s medical specialist or general practitioner and will be used in the training of support staff at school through the Schoolcare Program. Please supply **all** information to ensure safety and quality of care are maintained. **Schoolcare Program training cannot be scheduled until all relevant medical information is received.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Student Information** | | | | | | | | | | | | | | |
| Student name |  | | | | | | | | | D.O.B. | | | | |
| School name |  | | | | | | | | | | | | | |
| **Diagnosis/conditions** | | | | | | | | | | | | | | |
| **Tube Feeding** | | | | | | | | | | | | | | |
| **Gastrostomy (PEG)** | | **Mic-key**  **Mini One**  **Kangaroo**  **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_  Size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **Medication required at school**  N  Y  Water flush:  Before medication \_\_\_\_\_\_\_ ml  After medication \_\_\_\_\_\_\_\_ ml | | | |
| **Gastrojejunal (PEJ)** | |
| **Nasogastric (NG)** | | Size \_\_\_\_\_\_\_\_\_\_\_\_\_ inserted to \_\_\_\_\_\_\_\_\_\_\_\_\_ cm | | | | | | | | |
| **Nasojejunal (NJ)** | |
| **Dietician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Formula type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Feed Amount:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ml **Feed times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Feed Frequency:**  Continuous  Bolus **Administration:**  Gravity  Syringe  Feed pump rate (ml/hr) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Water flush:** Before feed \_\_\_\_\_\_\_\_\_ ml After feed \_\_\_\_\_\_\_\_ ml **Venting:** Before use  Y  N After use  Y  N  **On hot days (over** \_\_\_\_\_\_\_ **degrees):** \_\_\_\_\_\_\_\_\_ ml extra water  **Formula to be mixed at school:**  Y  N if yes, please describe how to mix formula \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **Any additional information i.e. choking risk, positioning etc. Please detail:** | | | | | | | | | | | Scheduled PEG replacement date, if known: | | | |
| **Oxygen Therapy** | | | | | | | | | | | | | | |
| **Delivery:**  Mask  Nasal Prongs **Rate:** \_\_\_\_\_\_\_\_\_L/min **Equipment:**  Concentrator  Cylinder  **Oximeter** **required:**  N  Y  Continuous monitoring  Spot checks  **Oximeter limits:** High pulse alarm \_\_\_\_\_\_\_\_\_ Low pulse alarm \_\_\_\_­­­­\_\_\_\_\_\_\_ Low oxygen alarm \_\_\_\_\_\_\_\_\_\_  **Emergency plan (i.e. increased oxygen rate, etc.)** | | | | | | | | | | | | | | |
| Other interventions required i.e. bag and mask support, etc. | | | | | | | | | | | | | | |
| **Tracheostomy** | | | | | | | | | | | | | | |
| Type of tube \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Suction catheter size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suction length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Suctioning** | | | | | | | | | | | | | | |
| Oral  Nasal  Yankauer or  Catheter size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suction device (equipment brand): **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Additional information i.e. when suctioning required, frequency etc. | | | | | | | | |
| **Stoma Care** (if stoma care is the sole medical need of the child, or if it accompanies epilepsy/diabetes management, this will  not be deemed eligible for Schoolcare and will require referral to Stomal Therapy at the child’s relevant hospital) | | | | | | | | | | | | | | |
| Colostomy/Ileostomy  Vesicostomy  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Active stoma care plan  Date of plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Stoma care required at school?  N  Y  Bag emptying required at school?  N  Y  If yes, please specify times/signs to look for:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Products used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Additional information i.e. input/output limits/expectations, signs of dehydration and management plan etc. | | | | | |
| RCH stomal nurse training  Date scheduled/received: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Epilepsy** (if epilepsy management is the sole medical need of the child, or if it accompanies stoma/diabetes management, this will not be deemed eligible for Schoolcare and will require referral to the [Epilepsy Foundation](http://epilepsyfoundation.org.au/) for information and training) | | | | | | | | | | | | | | |
| Has a seizure occurred in the last three years?  N  Y  Seizure frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is preventative medication currently being taken?  N  Y  Is emergency medication prescribed by the doctor?  N  Y  If Yes to any of these questions, complete and attach an  [**Epilepsy Foundation Management Plan**](http://epilepsyfoundation.org.au/epilepsy-management-plans/)and **Emergency Medication Management Plan** (also found at this link) as required | | | | | | | | \*Please note: **Schoolcare Program** **training can only be scheduled once current and valid epilepsy plans are provided.**    Date of plan(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Epilepsy management documentation remains current for 12 months and must be reviewed and updated annually.** | | | | | | |
| **Hypoglycaemia/Hyperglycaemia Management** (if diabetes is the sole medical need of the child, or if it accompanies stoma/epilepsy management, this will not [be deemed eligible for the Schoolcare Program. Please see department website: Diabetes](https://www2.education.vic.gov.au/pal/diabetes/policy)) | | | | | | | | | | | | | | |
| Type 1 diabetes  Type 2 diabetes  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_ | Is insulin prescribed for administration at school?  N  Y  Insulin type/s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Delivery mode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Blood Sugar Level test required (please specify acceptable range and when to be tested)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | Action & Management plan for hypoglycaemia/hyperglycaemia/ diabetes (please attach)  Date of plan(s): \_\_\_\_\_\_\_\_\_\_\_\_  **Ambulance** - When to call  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Other** (please specify care need not otherwise listed) | | | | | | | **Relevant care/action plans** (please attach) | | | | | | | |
| * **­­­­­­­­­­** | | | | | | | **­­­**  Allergy  Asthma | | | | | | **­­­**  Anaphylaxis  Other | |
| **Medical Practitioner Details**  **(child’s medical specialist, paediatrician, GP)** | | | | | | | | | | | | | | |
| **Name** | | | | | | | | **Email** | | | | | | |
| **Organisation and/or address** | | | | | | | | | | | | | | **Ph.** |
| **Signature of MP/Specialist** | | | | | | | | | | | | | | **Date** |
| **Parent/Carer Details** | | | | | | | | | | | | | | |
| **Name** | | | | **Signature** | | | | | | | | | | **Date** |