



MEDICAL INFORMATION FORM

1. MEDICAL INFORMATION

Student Name			
Medicare Number			
Medicare Expiry		Reference Number	
Emergency Contact		<input type="checkbox"/> Parent/Carer <input type="checkbox"/> Other	
Name			
Relationship			
Phone	Home		
	Work		
	Mobile		
Additional Emergency Contact		<input type="checkbox"/> Parent/Carer <input type="checkbox"/> Other	
Name			
Relationship			
Phone	Home		
	Work		
	Mobile		

2. MEDICAL CONDITIONS

ALLERGIES – THESE CAN INCLUDE ALLERGIES TO INSECT STINGS, DRUGS, LATEX, FOOD (E.G. NUTS, EGGS, PEANUTS) OR OTHER.

If your child has an allergy, please specify in the box below.

Allergy to			
Has a doctor diagnosed this allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is this a severe allergy (anaphylaxis) <i>Anaphylaxis is severe, potentially life-threatening, allergic reaction</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has your child been hospitalised with a severe allergic reaction (anaphylaxis) or any other allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does your child have an ASCIA Action Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, is the plan attached?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has your child been prescribed adrenaline autoinjector (i.e. EpiPen)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<p><i>If your child has been prescribed an adrenaline autoinjector, you will need to provide the school with one (and renew prior to expiry date). Each time your child is prescribed a new adrenaline autoinjector the doctor should issue an updated ASCIA Action Plan for Anaphylaxis. It is important that any updated plan is provided to the school.</i></p> <p>ASCIA Action Plans must be updated and provided to the College on an annual basis.</p>			
Does your child have any dietary requirements? If yes, please provide further information.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	



Please list any other medications prescribed for this allergy (e.g., antihistamine)	
<u>MEDICAL CONDITIONS OTHER THAN ALLERGIES AND ANAPHYLAXIS (e.g) ASTHMA, ASTHMA< SEVERE ASTHMA, DIABETES, EPILEPSY</u>	
Please identify and provide details below of any other medical condition for which your child is being treated	
Medical Condition	
Has a doctor diagnosed this allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child been hospitalised with this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have a documented action plan from a doctor? (e.g. asthma action plan)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, is the plan attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Please note: Asthma Action Plans must be updated annually and provided to the College on an annual basis.</i>	
Has your child been prescribed medication for this condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the prescribed medication? <i>The College will require further details in relation to prescribed medication on enrolment.</i>	
<u>DOES YOUR CHILD HAVE ANY FURTHER DIAGNOSIS?</u>	
Please identify and provide details below.	
Primary Diagnosis	
Other Diagnosis	
Does your child have NDIS Funding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In the process of applying
Does your child wear glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any further comments regarding your medical condition?	

**3. MEDICATIONS****Does the student take any medication?** *(If yes, please fill in the table below)*☐ Yes ☐ No

Name of Medication	Dosage Information	Home	School	Time

*If Medications are to be administered at school, please complete a Health Care Medication Plan***Are there any dietary restrictions or other medications that may cause a reaction while the student is taking the above medication?**

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Please indicate your student's current swimming ability for future activities involving water, such as sport and swimming carnivals
☐ Non-Swimmer
 ☐ Weak Swimmer
 ☐ Average Swimmer
 ☐ Strong Swimmer
4. ADMINISTRATION OF PARACETAMOL / OTHER MEDICATIONS AND MEDICAL TREATMENT**PARACETAMOL ADMINISTRATION**

☐ I give permission for my child, _____ to be administered Paracetamol when required, in accordance with dosage recommendations. A phone call to parent/carers will be made prior to administration to confirm dosage and time.

Please note a letter from your doctor is required and medication to be supplied.

☐ I do not give permission for Paracetamol to be administered.

MEDICAL TREATMENT:

I consent to the college seeking such medical advice on behalf of my child as the college sees fit in the event of an accident or illness. If in the opinion of an attending medical practitioner my child requires urgent medical attention or treatment, I give permission for such treatment to occur. I give consent for the college to call for the assistance of an Ambulance where it is deemed necessary for the safety and wellbeing of my child.

I certify to my knowledge that my child does not suffer from an illness or disability which might interfere with or inhibit any medical attention or treatment that has not previously been disclosed in the medical advice above.

I understand that the college will take all reasonable care in the event my child suffers an accident or illness, that the college will not be responsible for the cost of any medical attention or treatment administered in such event nor will the college be responsible directly or indirectly for any of omission of any medical practitioner attending or treating my child.

Parent/Carer 1 Signature		Date	
Parent/Carer 2 Signature		Date	