

STUDENT MEDICAL AND PERMISSION FORM

STUDENT DETAILS									
First Name		Surname							
Home Phone:			Other Phone						
Address									
Gender: Male Female									
Do you identify as an Aboriginal or Torres Strait Islander Person: Yes ☐ No ☐									
PARENT/EMERGENCY CONTACT DETAILS									
Contact Person 1			Relationship:						
Phone (Home)			Phone (other)						
Contact Person 2			Relationship:						
Phone (Home)			Phone (Other)						
Contact Person 3			Relationship:						
Phone (Home)			Phone (Other)						
Doctors Name:			Dentist Name:						
Phone:			Phone:						
MEDICAL DETAILS									
Date of Birth: / /		eight:	kgs	Height:	cr	n			
Does your child have any o	of the follo	wing?							
Asthma Yes ☐ No ☐			Mental Health Is:	sue	Yes 🗌	No □			
If yes, date of last episode & any medication you use (attach			If yes, please state						
action plan) Is the condition severe?	Yes □	No □	Is the condition s	ovoro2	Yes □	No □			
Allergies – Food	Yes \square	No П	Diabetes	evere:	Yes 🗆	No 🗆			
If yes, please state	163 <u></u>	INO []	Diabetes		163 []	ио П			
Is the condition severe?	Yes 🛚	No 🗆	Is the condition s	severe?	Yes □	No □			
Allergies – Drug	Yes 🗌	No 🗆	Fears/Phobias		Yes 🗆	No 🗆			
If yes, please circle Penicillin Morphia C	Other:		If Yes, please state						
Is the condition severe?	Yes 🗆	No □	Is the condition s	severe?	Yes \square	No □			
Allergies – Other	Yes 🗆	No □	Epilepsy		Yes □	No 🗆			
If yes, please state	_	_	,		_	_			
Is the condition severe?	Yes 🗆	No 🗆	Is the condition s		Yes 🗆	No 🗆			
Bleeding Condition	Yes 🛚	No 🗆	Do you have any If yes, please state	·	Yes	No 🗆			
Is the condition severe?	Yes 🗆	No 🗆	Is the condition s		Yes 🗌	No 🗆			
Heart Problems/Disease	Yes 🗆	No 🗆	Respiratory prob	lems	Yes 🗆	No 🗆			
If yes, please state Is the condition severe?	Yes □	No 🗆	المعالمة الم		Vac 🗖	м. П			
			Is the condition s Other Condition	evere?	Yes 🗆	No 🗆			
High Blood Pressure Is the condition severe?	Yes □ Yes □	No □	If yes, please state		Yes 🗌	No 🗆			
		_ -	Is the condition s	evere?	Ves 🗆	No 🗆			

Last Tetanus injections: Within the last 2 years: ☐ Within the last 10 years: ☐ Never ☐ If your child is off school grounds, do you give First Aid personnel permission to administer Paracetomol (S2 drug)? Yes ☐ No ☐ Do you give your child permission to self administer asthma medication (S3 drugs)? Yes ☐ No ☐									
Current Medications: list all medications you presently use – including prescription and over the counter medication									
Medication	Dosage	Fre	equency	Treatment for					
Medication	Oosage	Fre	equency	Treatment for					
Medication	Dosage	Fre	equency	Treatment for					
Medication[Oosage	Fre	equency Treatment for						
Note: Permission to Administer Medication Form must be completed and returned to the office along with labelled medication to allow staff to administer any of the above medications. Students are NOT permitted to hold medication on their person or in their bags. Asthma medications and epipen are allowable if needed.									
Swimming Ability: Excellent Confident Some Confidence Not Confident Do you have any special dietary requirements? Yes No No If yes please state									
Medicare No:		_	Private Health Name of Fund:	Fund If Yes, please state details					
Place on card: Expiry	date: / /	/ Membership No:							
Has your child received any assist	stance from or Yes		n in contact with						
Guidance Officer	Yes	No							
Hearing Impaired Services	Yes	No							
Psychologist	Yes	No							
Psych, Analyst	Yes	No							
Physically Handicapped Services	Yes	No.							
Speech Therapists	Yes	No							
Visual Services	Yes	No							
Note: If you have answered Yes to any of the above, please attach any relevant reports to this form.									
PARENTAL/GUARDIAN CONSENT									
X-rays and all medical expenses are the responsibility of the parents/guardians. Parent/guardian gives the college permission to authorize medical treatment as required. The parent will normally be contacted before medical treatment is administered. In emergency cases the ambulance service will normally transport students to the nearest public hospital. The information provided on this form will only be made available to relevant college personnel. But this information may be provided to ambulance, paramedical or medical providers should an emergency occur. Parent/Guardian									
Name:									
Parent/Guardian Signature:									
Date									