MEDICAL INFORMATION FORM ORRoroo AREA SCHOOL

Surname of Children: _____

Father's Name: _____ **Mother's Name**: _____

Address: _____ **Home Phone:** _____

Mobile: _____ **Father's Work No:** _____ **Mother's Work No:** _____

Names of Children				
Dates of Birth				
Year Levels				

Medical Conditions (Please use the back of form for any other important details)

Epilepsy				
Heart Condition				
Ear Disorder/Deafness				
Respiratory (incl Asthma)				
Allergies				
Diabetes				
Physical Disabilities				
Medical Aids				
Prescribed Medications				
Tetanus Immunization				
Date of Last Booster				
Any other information				

Names and ages of other children in the family:

_____

FOR EMERGENCY USE ONLY

Name of Family Doctor: _____

Address: _____ Phone No: _____

Family Medicare Card Number: _____

Emergency Contact: (for use when parents can not be contacted)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

In the event of sickness or accident and when no contact can be made, I give permission for my children to receive immediate medical attention from the nearest Doctor or Medical Centre, and agree to pay all medical and dental expenses incurred.

Signature of Parent/Guardian: _____

NB the information requested on this sheet will be considered confidential by the school and will be treated accordingly.

FURTHER MEDICAL INFORMATION

Student's Name: _____

What is the nature of the condition:	

How could it affect the student:	

What treatment is required:	

Is it necessary that emergency medication be issued to the school? YES/NO

If you have answered YES, please give details and issue medicine to be kept in the Sick Room Medicine Cupboard at school.

Any medication required by students should be sealed in its appropriate dispensing container with dose stated, mode of administration, expiry date of medication and any other information.

Please notify the school if there are any changes to the above information.

Asthma

Family Name (Surname:

Does your child, or any of your children have Asthma? Yes/No

Please provide the following details for each child affected?

1. Child's Name: Date of birth:
2. Mild/Moderate/Severe Condition
3. What medication is being used at home for the treatment of the asthmatic condition?
4. What medication is being used at school for the treatment of the asthmatic condition?
5. Can your child handle his/her treatment independently at school or does he/she need held and support from a member of the staff?
6. Does your child suffer from Exercise Induced Asthma? Yes/No
7. Do you have an individual asthma action plan for your child arranged in consultation with your doctor? Yes/No

Parent's signature: ……..

Dated: / /2016