TOWNSVILLE GRAMMAR SCHOOL

MEDICAL INFORMATION

OFFICE USE ONLY
PARENT CODE

Please complete **ALL** sections of the following form and ***NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES OF ADDRESS AND/OR MEDICAL UPDATES.***

SURNAME: ..... **GIVEN NAME/S:**.....

Male / Female DOB: ..... Grade: ..... Year of Entry: .....

Full Name (Mother/Guardian): .....

Full Name (Father/Guardian): .....

Residential Address: .....

..... Post Code: .....

TELEPHONE NUMBERS

Mother/Guardian Home ..... Work..... Mobile .....

Father/Guardian Home ..... Work..... Mobile.....

EMERGENCY CONTACT (if parents/guardians cannot be contacted)

Relative/Friend: Name .....

Phone Numbers: Home..... Work ..... Mobile .....

Preferred Doctor: ..... Phone .....

Preferred Dentist: ..... Phone .....

HEALTH COVER

Private Health Fund .....**Yes / No** Fund Name..... Membership No.....

Family Medicare No .....

No. next to Student's Name ..... Expiry Date .....

IN CASE OF ILLNESS OR ACCIDENT

If the School is unable to contact the parents/guardians or emergency contact person to collect the student for treatment, the School will take the student to the nearest available practitioner, the cost of which will be met by the parent.

If the situation requires emergency action, an ambulance will be called and the student will be taken to an accident or emergency department, the cost of which will be met by the parent.

ANALGESICS

Do you give permission for the School Nurse or designated First Aid Officer to administer

oral analgesics if he or she determines these are required? **Yes** **No**

(On each occasion, attempts will be made to contact the parents to obtain verbal approval.)

If "yes", please state the dosage: .....

Signed: .....

MEDICAL HISTORY

Has your child ever suffered from any of the following? If so, please provide details below:

1. Asthma	Yes	No
2. Allergies	Yes	No
3. Heart Condition	Yes	No
4. Sight or Hearing Disorder	Yes	No
5. Fear/Phobias	Yes	No
6. Diabetes	Yes	No
7. Epilepsy	Yes	No
8. Bleeding Disorder	Yes	No
9. Muscular/Skeletal – Ankle/Back/Knee/Joint Problems	Yes	No
10. Any Injury/Operation in the last 12 months	Yes	No
11. Headaches, Nose Bleeds	Yes	No
12. Other Conditions (Conditions which may be aggravated by fully participating in School programmes e.g. sport, camps etc.)	Yes	No
13. Does your child wear glasses or contact lenses?	Yes	No
14. Is your child currently on any medications?	Yes	No

Relevant details:

Special Dietary Needs:

Date of last Tetanus Injection:

SIGNATURE

Father/Parent/Guardian .....

Mother/Parent/Guardian ..... Date .....

EXTENDED BOARDING MEDICAL INFORMATION

EXTENDED MEDICAL HISTORY

1. Travel Sickness Yes No

2. Surgical Procedures Yes* No

**If YES, please detail:*

3. Student's Blood Type

IMMUNISATION	DATE OF LAST IMMUNISATION
OPV (Oral Polio Vaccine – Polio)	
CDT (Triple Antigen 5 years of age)	
MMR (Measles, Mumps, Rubella)	
ADT (Adult Diptheria /Tetanus)	
Hepatitis A	
Hepatitis B	
Other *(please detail)*	

Has the student suffered any of the following? Please note year of illness:

Measles	Mumps	Chicken Pox	Rubella
Malaria	Whooping Cough	Dengue Fever	Ross River Fever
Hernia	Bronchitis	Tonsillitis	Glandular Fever
Scarlet Fever			

ASTHMA MANAGEMENT SECTION

Please list prescribed medications:

NAME	DOSAGE	INSTRUCTIONS

1. Does the student use/require a spacer? Yes No
2. How often does the student suffer from asthma?
3. Has the student ever been hospitalised for asthma? Yes No
4. Has the student ever been admitted to the intensive care unit for asthma? Yes No
5. List known trigger factors:
6. Is the student under special care for their asthma? Yes* No

**If YES, please detail:*

ALLERGIES

Please specify what the student is allergic to:

FOOD	MEDICATIONS	INSECT BITES	OTHER

Is the reaction:

1. LOCALISED (rash/itch/swelling at the point of contact)? Yes No

2. SYSTEMIC (rash/itch/swelling away from the site of contact)? Yes No

3. ANAPHYLACTIC (severe breathing problems, swelling of the body) Yes No

Please detail the SIGNS AND SYMPTOMS of the reaction:

4. Has the student ever been ADMITTED TO HOSPITAL for an allergic reaction? Yes No

**If YES, please detail:*

5. Does the student TAKE ANY MEDICATION TO PREVENT ALLERGIES? Yes* No

**If YES, please detail:*

MEDICATION	DOSAGE	INSTRUCTIONS

In the event of an allergic reaction what EMERGENCY TREATMENT is preferred?

6. Does the student require ADRENALINE (EPI-PEN) for allergic reactions? Yes* No

**If YES, please detail:*

7. Does the student wear a MEDICAL ALERT BRACELET OR PENDANT Yes No

DENTAL

1. Has your child had a recent dental check? Yes* No

**If YES, please detail:*

2. Do you wish your child to have regular dental checks? Yes No

Emergencies Only

3. Preferred Dentist: Dentist on Paxton (28 Paxton Street, across the street from school)
Dental Clinic
Other*

**If OTHER, please detail:*

OTHER

MALARIA PROPHYLAXIS (applicable only to malaria prone regions)

1. Our preferred malaria prophylactic is:

2. Our preferred schedule is:

I/We give consent to nursing staff to administer prophylactic as per schedule.

Signature:

PRINT NAME:

SWIMMING ABILITY

1. Please tick Unable to swim Beginner Intermediate Advanced

PARENT/GUARDIAN CONSENT SECTION

I/We hereby give consent for the Nursing staff to:

- Initiate medical assistance, and/or treatment, and/or administer medication to my child where deemed necessary.
- Sign necessary forms for anaesthetic for emergency treatment. Every effort will be made to contact next of kin initially.

NOTE: In the event of an emergency, your child will be taken to the Emergency Department of The Townsville Hospital for treatment.

SIGNATURE

Father/Parent/Guardian .....

PRINT NAME .....

Mother/Parent/Guardian .....

PRINT NAME .....

Date .....