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.***

CHILD'S SURNAME: …….. **GIVEN NAME(S):** ……

Child's Address: .....

Post Code:…… Cultural Background:……

Male / Female DOB: ……/……/…… Year Level:…….. (eg Year 7) Year of Entry:..... …… (eg 2017, 2018)

FATHER/PARENT/GUARDIAN 1 DETAILS:

Full Name: …….. .....

Address of Father/Parent/Guardian 1: .....

Post Code: …… Cultural Background:……

Telephone Number(s): Home …….. Work …… Mobile ……..

MOTHER/PARENT/GUARDIAN 2 DETAILS:

Full Name: .....

Address of Mother/Parent/Guardian 2: .....

Post Code:…… Cultural Background:……

Telephone Number(s): Home ..... Work .... Mobile ……

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? (On each occasion, attempts will be made to contact the parents to obtain verbal approval. ☐ **Yes** ☐ **No**

If "yes", please state the dosage: …… **Signed:** ……

(Please turn over to complete)

MEDICAL PRACTITIONER DETAILS

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

Medical Practice Address: .....

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

Dental Practice Address: .....

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

Date of last Tetanus Injection:

Special Dietary Needs:

Any other relevant Medical Information (use extra sheets if required):

SIGNATURE(S): Date ……/……/……

Father/Parent1/Guardian…….. … ……. **Mother/Parent2/Guardian**…….. ……