TOWNSVILLE GRAMMAR SCHOOL

MEDICAL INFORMATION – DAY STUDENTS

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: ..... Child's Given Name:.....

Child's Address:.....

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

Culture: ..... Religion:.....

Male / Female DOB: ...../...../..... Year Level:..... (eg Year 7) Year of Entry:..... (eg 2021)

FATHER/PARENT/GUARDIAN 1 DETAILS:

Full Name: .....

Address of Father/Parent/Guardian.....

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

Culture: ..... Religion:.....

Telephone Number(s): (H) ..... (W) .....

(M) .....

MOTHER/PARENT/GUARDIAN 2 DETAILS:

Full Name: .....

Address of Mother/Parent/Guardian.....

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

Culture: ..... Religion:.....

Telephone Number(s): (H) ..... (W) .....

(M) .....

HEALTH COVER

Private Health Fund: Yes / No Fund Name.....

Membership No .....

Family Medicare Number: ..... 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, as per recommended dose for child's age / weight?

Paracetamol (Panadol)	☐	**Yes**	☐	**No**
Ibuprofen	☐	**Yes**	☐	**No**
Antihistamine	☐	**Yes**	☐	**No**

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

Please provide 'Asthma Medical Action Plan' available here:
https://www.tgs.qld.edu.au/enrolments/commencement-pack/

2. Allergies ☐ Yes ☐ No

Please provide 'Allergy Medical Action Plan' available here:
https://www.tgs.qld.edu.au/enrolments/commencement-pack/

3. Heart Condition ☐ Yes ☐ No
4. Sight or Hearing Disorder ☐ Yes ☐ No
5. Mental Health: Anxiety, depression or panic attacks ☐ Yes ☐ No
6. Fear/Phobias ☐ Yes ☐ No
7. Diabetes ☐ Yes ☐ No

Please provide 'Diabetes Medical Action Plan' available here:
https://www.tgs.qld.edu.au/enrolments/commencement-pack/

8. Epilepsy ☐ Yes ☐ No

Please provide 'Epilepsy Medical Action Plan' available here:
https://www.tgs.qld.edu.au/enrolments/commencement-pack/

9. Bleeding Disorder ☐ Yes ☐ No
10. Muscular/Skeletal – Ankle/Back/Knee/Joint Problems ☐ Yes ☐ No
11. Any Injury/Operation in the last 12 months ☐ Yes ☐ No
12. Headaches ☐ Yes ☐ No
13. Nose Bleeds ☐ Yes ☐ No
14. Other Conditions ☐ Yes ☐ No

(Conditions which may be aggravated by fully participating in School programmes e.g. sport, camps etc)

15. Does your child wear glasses or contact lenses? ☐ Yes ☐ No
16. Is your child currently on any medications? ☐ Yes ☐ No

If so, please list:

If medications are required to be administered whilst at School, please complete 'Medical Management Plan' available here: ***https://www.tgs.qld.edu.au/enrolments/commencement-pack/***

17. Relevant details of Medical Condition:

If condition requires management whilst at School, please complete 'Medical Management Plan' available here: https://www.tgs.qld.edu.au/enrolments/commencement-pack/

18. Special Dietary Needs:

SIGNATURE(S):

Date ……/……/……

Father/Parent1/Guardian……

Mother/Parent2/Guardian……