TOWNSVILLE GRAMMAR SCHOOL

OFFICE USE ONLY - PARENT CODE

MEDICAL INFORMATION – BOARDING

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:..... Cultural Background:.....

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:..... Cultural Background:.....

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

(M) .....

MOTHER/PARENT/GUARDIAN 2 DETAILS:

Full Name: .....

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

.....

Post Code:..... Cultural Background:.....

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……

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

4. Medicare Immunisation Statement attached? ▯ Yes ▯ No

If an international student, please provide a letter from your doctor or attach other immunisation history documentation.

5. 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			

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

Preferred Dentist: ▯ Dentist on Paxton (across from School) ▯ 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 or First Aid officer 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 .....