TAS
TRINITY ANGLICAN SCHOOL

STUDENT MEDICAL FORM - 2018

C O N F I D E N T I A L

BOTH SIDES TO BE COMPLETED BY PARENT OR GUARDIAN AND RETURNED AS SOON AS POSSIBLE

STUDENT'S NAME: _____ GENDER : F / M

DOB: _____ CAMPUS: WRJ / KBJ / WRS YEAR LEVEL: _____

RESIDENTIAL ADDRESS:_____ P/CODE: _____

MEDICARE NUMBER: _____ PREFERRED HOSPITAL: _____

PRIVATE HEALTH INSURANCE FUND: _____

EMERGENCY CONTACT DETAILS *in order of priority*:

Name	Private Address	Private Phone	Business Address	Business and/or Mobile Phone
1.				
2.				
3.				

Your child's swimming ability in still water is (circle one):
Nil 10metres 25metres 50metres 100metres More than 100metres

ALLERGIES: YES or NO (If yes, Detail : _____)

Please give details of any allergies to medication _____

If your child suffers from asthma, hay fever, fits, fainting spells, diabetes, or any other illness requiring medication, the appropriate medication must be left in the sick bay. Clearly label medication with child's name, dosage and frequency of administration.

DOES THE SCHOOL HOLD MEDICATION IN THE SICK BAY FOR THIS CHILD? YES or NO
Type of Medication:

_____

DOES YOUR SON/DAUGHTER HAVE A MEDICAL CONDITION THE SCHOOL NEEDS TO BE AWARE OF? YES or NO
SHOULD THIS MEDICAL CONDITION REMAIN CONFIDENTIAL? YES or NO

MEDICAL CONDITION:

Does your son/daughter suffer from:

Allergies	Yes/No	Hayfever	Yes/No
Asthma	Yes/No	Headaches/Migraine	Yes/No
Bed Wetting	Yes/No	Heart or Lung complaints	Yes/No
Diabetes	Yes/No	Menstrual Pain	Yes/No
Epilepsy	Yes/No	Sleep Walking	Yes/No
Fits or Fainting Spells	Yes/No	Travel Sickness	Yes/No

If YES, please give details below, or attach a note.

_____

_____

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IMMUNISATIONS: (Please include details of immunisation, eg Tetanus, Rubella, etc.)

Immunised for: _____ Year _____

Immunised for: _____ Year _____

Immunised for: _____ Year _____

DOCTOR DETAILS:

PRACTITIONER TYPE: (eg: GP) _____ PRACTITIONER'S NAME: _____

DR'S TELEPHONE NO: _____

Is your child taking any medication or under any type of treatment, or has your child any condition or physical disability, which may prevent full involvement in the School activities? **Yes/No**

If YES, please give details below, or attach a note.

_____

_____

Has your child contracted, or been in contact with, any infectious diseases (including normal childhood diseases) in the past three (3) months? **Yes/No** **If YES, please give details below, or attach a note**.

_____

_____

Are there any other details the school should be made aware of?

_____

_____

I understand that whilst every effort will be made to contact me in an emergency, I hereby authorise the Principal or his appointed Officer to give permission for medical treatment (including Ambulance transport, the administering of an anaesthetic, blood transfusion or the performance of any surgical operation) to be given to my son/daughter. I accept responsibility for any expenses incurred.

I agree to my child's returning home, if necessary, in the event of illness or injury and agree to pay any expenses incurred. I undertake to keep the School informed of any changes to the physical and medical condition of my child.

SPECIAL INSTRUCTIONS IN THE EVENT OF AN ACCIDENT OR ILLNESS IF THE ABOVE AUTHORITIES ARE NOT COMPLETED.

_____

_____

_____

NAME OF PARENT/GUARDIAN: _____ SIGNATURE: _____

RELATIONSHIP TO STUDENT: _____ DATE: _____

(**Student medical records are updated each year**. Please return this form as soon as possible so this information can be updated for your child).