All Souls St Gabriels School

CELEBRATING 100 YEARS *in* 2020

Medical History and Authorisation:

Student Name: _____ DOB: _____

Parent 1 Name _____ Relationship to student _____

Mobile: _____ Home: _____ Work _____

Parent 2 Name _____ Relationship to student _____

Mobile: _____ Home: _____ Work _____

Alternative Contact _____ Relationship to student _____

Mobile: _____ Home: _____ Work _____

MEDICAL INFORMATION:
Please give full details for each of the following (e.g. severity, medication, Date of last attack/operation/injury)

IMMUNISATION:

Are you child's tetanus immunisations up to date? ❒ **Yes** ❒ **No**

Date of last tetanus booster? _____

Are all other immunisations up to date? ❒ **Yes** ❒ **No**

If **NO**, please provide details? _____

CURRENT AND PRESCRIBED MEDICATIONS:

Medication & Dosage _____

Reason for use: _____

Instructions for use: _____

Medication & Dosage _____

Reason for use: _____

Instructions for use: _____

Medication & Dosage _____

Reason for use: _____

Instructions for use: _____

PAIN RELIEF:

Permission to administer paracetamol: ❒ **Yes** ❒ **No**

Permission to administer Ibuprofen: ❒ **Yes** ❒ **No**

Permission to administer antihistamine: ❒ **Yes** ❒ **No**

ASTHMA:

Does your child suffer from Asthma? ❒ **Yes** ❒ **No**

Severity: _____

Has your child been hospitalised with asthma? ❒ **Yes** ❒ **No**

When: _____

Frequency: _____

Medication & Dosage _____

Instructions for use: _____

MEDICATION & DRUG ALLERGIES:

Allergic to: _____

Allergic reaction: _____

How Managed: _____

Allergic to: _____

Allergic reaction: _____

How Managed: _____

OTHER ALLERGIES (including Anaphylaxis):

Allergic to: _____

Allergic reaction: _____

How Managed: _____

Allergic to: _____

Allergic reaction: _____

How Managed: _____

Allergic to: _____

Allergic reaction: _____

How Managed: _____

ANAESTHETIC:

Is your child tolerant to anaesthetic?

Local: ❒ Yes ❒ No ❒ Don't know

General: ❒ Yes ❒ No ❒ Don't know

DIABETES:

Does your child have diabetes? ❒ **Yes** ❒ **No**

Type: _____

How Managed: _____

NOSE BLEEDS:

Does your child suffer from nose bleeds? ❒ **Yes** ❒ **No**

Frequency: _____

How Managed: _____

TRAVEL SICKNESS:

Does your child suffer from travel sickness? ❒ **Yes** ❒ **No**

Frequency: _____

How Managed: _____

OTHER MEDICAL ISSUES OR ILLNESSES:

Does your child have any other medical issues or illnesses? ❒ **Yes** ❒ **No**

Please list:

_____

_____

RECENT INJURIES OR OPERATIONS:

Has your child had any recent injuries or operations? ❒ **Yes** ❒ **No**

Please list:

_____

_____

SPECIAL DIETRY REQUIREMENTS:

Does your child have any special dietary requirements? ❒ **Yes** ❒ **No**

Please list:

_____

_____

MEDICAL INSURANCE DETAILS:

Medicare Card #: _____ Ref No: ____ Expiry Date: _____

Health Care Card #: _____ Expiry Date: _____

Name of Private Health Fund: _____ Membership No: _____

I hereby authorise the obtaining on my behalf of such medical assistance as my son/daughter may require in the event of accident or illness and guarantee to meet any costs incurred.

I authorise the administering of anaesthetic if the medical officer attending deems this necessary.

Signature of Parent 1: _____

Name of Parent 1: _____

Date: _____

Signature of Parent 2: _____

Name of Parent 2: _____

Date: _____

These details are requested to enable contact to be made with parents/guardians, to aid in the event of an emergency and are strictly confidential.