St Paul's School

Medical Information

CONFIDENTIAL

General Information			
Students Given Name		Students Surname	
Address		Parent Code: Student Code:	
Year Level		Date of Birth	
Medicare Number			Expiry Date
Private Health Insurance ☐ YES/NO ☐		Membership Details	
Can your child swim? ☐ YES/NO ☐		How far in metres?	

Emergency Contact Information (if neither parent is available)	
Name	Relationship (ie, Aunt / Friend / Grandparent)
Phone Number	Mobile Number

Medical Information			
Immunisation			
A copy of the student's most current immunisation record **must** be attached to this form.			
Does your Child have:			
Allergies			☐ YES / NO ☐
If yes please specify what the student is allergic to:			
FOOD	MEDICATIONS	INSECT BITES	OTHER

Is the reaction (please indicate)		
ANAPHYLACTIC ☐ YES / NO ☐ (severe breathing problems, swelling of the body)	**SYSTEMIC** ☐ YES / NO ☐ (rash/itch/swelling away from the site of contact)?	**LOCALISED** ☐ YES / NO ☐ (rash/itch/swelling at the point of contact)?
Please detail the SIGNS AND SYMPTOMS of the reaction:		

Has the student ever been ADMITTED TO HOSPITAL for an allergic reaction? **If YES, please detail:*	☐ YES / NO ☐
Does the student require ADRENALINE (EPI-PEN) for allergic reactions? **If YES, please detail:*	☐ YES / NO ☐
Does the student TAKE ANY MEDICATION TO PREVENT ALLERGIES? **If YES, please detail:*	☐ YES / NO ☐

Asthma		☐YES / NO☐
Please list prescribed medications:	Medication Name: Dosage : Instructions:	
Does the student use/require a spacer?		☐YES / NO☐
How often does the student suffer from asthma?		
Has the student ever been hospitalised for asthma?		☐YES / NO☐
Has the student ever been admitted to the intensive care unit for asthma?		☐YES / NO☐
List known trigger factors:		
Is the student under special care for their asthma?		☐YES / NO☐
**If YES, please detail*		
Does the student have an Asthma Management Plan?		☐YES / NO☐
**If YES please provide a copy*		
Diabetes		☐YES / NO☐
Medication and treatment *Please detail*		
Epilepsy		☐ YES/NO ☐
Description of recent seizures		
How long since last seizure?		
Medication and Treatment *Please detail*		
Hearing Problems		☐YES / NO☐
**If YES, please detail:*		
Visual Problems		☐YES / NO☐
**If YES, please detail:*		
Any other Medical Conditions		☐YES / NO☐
**If YES, please detail:*		
A physical disability		☐YES / NO☐
**If YES, please detail:*		
Does your child take routine medication or treatment		☐YES / NO☐
**If YES, please detail:*		
Has your child been admitted to hospital during the past 12 months		☐YES / NO☐
**If YES, please detail:*		
Please provide copies of medical action plans signed by your student's doctors for any of the above conditions?		☐Yes/No☐

Signature of Parents / Guardians 1. _____

2. _____