EARLY LEARNING CENTRE

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. _____