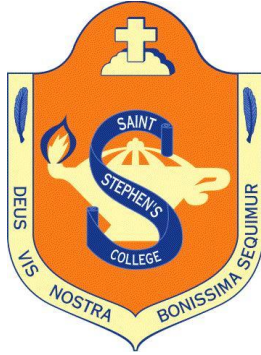


Name:
Year Level:
Parent Signature:

OFFICE USE ONLY

Date Received:
Date Entered:



Saint Stephen's College Medical Information Form

Please ensure that this form is completed and returned to the Health Centre prior to your child commencing.

The information provided in this document is confidential and will only be shared with the relevant staff members when necessary.

Please complete this form in as much detail as possible to assist us in the event of a medical emergency. Should there be any changes to your child's medical details, please inform the school in writing as soon as possible.

Saint Stephen's College suggests that you retain a copy of this form for your records.

Saint Stephen's College
ABN 31 071 134 024
Reserve Road, COOMERA QLD 4209
Phone: 07 5573 8615 Fax: 07 5573 8688
mmcbride@ssc.qld.edu.au
CRICOS PR01938G

STUDENT INFORMATION

Family Name: _____
Given Name(s): _____
Preferred Name: _____
Religion: _____
Address: _____
Town/Suburb: _____
State: _____
Country: _____ Post/Zip Code: _____
Home Phone: _____
Parent Mobile: Mother: _____ Father: _____
Date of Birth: _____

EMERGENCY CONTACT DETAILS

**An Emergency Contact is the first person to be contacted if a parent/guardian is NOT AVAILABLE
PLEASE DO NOT LIST PARENT DETAILS**

Full Name: _____
Relationship to child: _____
Home Phone: _____
Business Phone: _____
Mobile Phone: _____

MEDICAL PRACTITIONERS AND MEDICARE DETAILS

Dentist: _____ Phone: _____
Doctor: _____ Phone: _____
Orthodontist: _____ Phone: _____
Specialist: _____ Phone: _____
Medicare No: _____
Private Health Fund Name: _____ No: _____

HOSPITAL DETAILS

Would you like your child to be taken to a **Private** or **Public** Hospital (Please Circle)

Please list your preferred choice should your child need to be take to hospital by Ambulance.

Preference 1: _____ Preference 2: _____

MEDICAL CONDITIONS

ADD / ADHD	Yes / No (Please Circle)	Specific Details:	
Accidents	Yes / No (Please Circle)	Specific Details:	
Allergies	Yes / No (Please Circle)	Specific Details:	
Anaphylaxis	Yes / No (Please Circle)	Specific Details:	
Anxiety/Panic Attacks	Yes / No (Please Circle)	Specific Details:	
Aspergers Syndrome	Yes / No (Please Circle)	Specific Details:	
Asthma	Yes / No (Please Circle)	Specific Details:	
Autism Spectrum Disorder	Yes / No (Please Circle)	Specific Details:	
Blood Disorders	Yes / No (Please Circle)	Specific Details:	
Diabetes	Yes / No (Please Circle)	Specific Details:	
Ear / Hearing Problems	Yes / No (Please Circle)	Specific Details:	
Eczema	Yes / No (Please Circle)	Specific Details:	
Epilepsy/convulsions/fits	Yes / No (Please Circle)	Specific Details:	
Eye / Sight Problems	Yes / No (Please Circle)	Specific Details:	
Hearing Impaired	Yes / No (Please Circle)	Specific Details:	
Heart Condition	Yes / No (Please Circle)	Specific Details:	

Migraines/Headaches	Yes / No (Please Circle)	Specific Details:	
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Physical Disability	Yes / No (Please Circle)	Specific Details:	
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Skin Condition	Yes / No (Please Circle)	Specific Details:	
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Other Illness	Yes / No (Please Circle)	Specific Details:	
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Other Illness 2	Yes / No (Please Circle)	Specific Details:	
------------------------	-----------------------------	-------------------	--

Other Illness 3	Yes / No (Please Circle)	Specific Details:	
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IMMUNISATIONS

Chickenpox:	Yes / No (Please Circle)	Year: _____
Hepatitis B:	Yes / No (Please Circle)	Year: _____
Hib Titer:	Yes / No (Please Circle)	Year: _____
Measles/Mumps/Rubella:	Yes / No (Please Circle)	Year: _____
Meningococcal:	Yes / No (Please Circle)	Year: _____
Oral Sabin:	Yes / No (Please Circle)	Year: _____
Tetanus:	Yes / No (Please Circle)	Year: _____
Triple Antigen 5:	Yes / No (Please Circle)	Year: _____

OTHER CURRENT MEDICATION

Medication (eg Multivitamins)	Method (eg orally)	Details

I hereby acknowledge that the information provided is accurate.

Signature of Parent / Guardian (Please circle): _____

Please print your name: _____ Date: _____

ASTHMA MANAGEMENT PLAN

Regular Medication: _____
Quantities and Dosages: _____
Additional Medications in case of an attack: _____
Do you know of any trigger factors: _____
Peak flow readings - Expected best: _____
Require Extra Medication: _____
Require Medical Assistance: _____
Other Information: _____

ALLERGIC REACTION MANAGEMENT PLAN

Allergy: _____
Signs and Symptoms: _____
What medication do you take (if any) for prevention of an allergic reaction? _____
What treatment is followed for an allergic reaction: _____
Have you at any time, suffered from any of the following:
 A Localised reaction (any rash/ itching / swelling at the sight of where poison has entered)
 A Systematic reaction (any rash / itching / swelling away from the sight where the poison has entered)
 An Anaphylactic reaction (severe breathing problems, swelling of body, emergency situation)
Do you suffer a systemic / anaphylactic reaction to allergy? Yes No
Is there a family history of anaphylaxis? Yes No
Have you been admitted to hospital for an allergic reaction? Yes No
Do you take adrenaline (Epi-Pen) when suffering from an allergic reaction? Yes No

IF YES TO ANY OF THE ABOVE PLEASE CONTACT COLLEGE NURSE

In Case of an Emergency, I grant the person in charge, authority to seek any necessary medical assistance. I also permit any emergency surgical, operative and medical treatment to be carried out and authorise general anaesthetic if it is advisable and necessary after consulting the appropriate medical authorities. I give permission to the person in charge, to administer the supplied emergency medication, if I am unable to do so myself. I declare that the information provided on this form is complete and correct.

Name: _____ Signature: _____ Date: _____