Name: .....

Year Level:.....

Parent Signature:.....

OFFICE USE ONLY

Date Received: .....

Date Entered: .....

Saint Stephen's College

Medical Information Form

It is a requirement of the College that this form be 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
hmiller@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 <u>if a parent/guardian is NOT AVAILABLE</u>
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 **<u>Private</u>** or **<u>Public</u>** 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:	
Physical Disability	Yes / No (Please Circle)	Specific Details:	
Skin Condition	Yes / No (Please Circle)	Specific Details:	
Other Illness	Yes / No (Please Circle)	Specific Details:	
Other Illness 2	Yes / No (Please Circle)	Specific Details:	
Other Illness 3	Yes / No (Please Circle)	Specific Details:	

IMMUNISATIONS

Immunisation up to date	Yes	No
Partially Immunised	Yes	No
Not Immunised	Yes	No

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** _____

ADMINISTRATION OF AN ANALGESIC TO STUDENTS POLICY

Analgesics (Panadol or Nurofen) may be administered to students under the following circumstances:

1) Such medication can **only** be given to the student by a registered nurse and only if it is the nurse's professional opinion that this is the best treatment at the time.
2) The College Nurse is a Registered Nurse.
3) For students in **Prep to Year 3**, the College Nurse will contact a parent or guardian of the child prior to administering an analgesic.
4) For students in **Years 4 to 12**, the College Nurse will administer analgesics where no signed "Refusal of permission to administer an analgesic" has been received by the College. In such cases, students will be issued with a note to inform their parents of the time, type and amount of medication administered.
5) Prior to the start of each academic year, all parents and guardians of students will receive information about the policy, and the "Refusal of permission to administer an analgesic" form.
   This information will be distributed to new students at the time of enrolment.

REFUSAL OF PERMISSION TO ADMINISTER AN ANALGESIC

If you **do not wish** the College Nurse to administer an analgesic to your child at her professional discretion, and wish to be contacted first, please sign and return the form below;
The College Nurse
Saint Stephen's College
PO Box 441
Oxenford, QLD 4210

Yours sincerely

Bob Nicol
Assistant to the Headmaster – Administration and Compliance

----✂----------✂----------✂----------✂----

REFUSAL OF PERMISSION TO ADMINISTER AN ANALGESIC

Name of Child/ren:_____

Class / Tutor Group:_____

I request that the College Nurse DOES NOT administer an analgesic to my child/ren, in Year 4 to 12, without contacting me by phone first.

Contact Numbers: **1.** _____ **2.** _____

3. _____

Parent/Guardian Signature: _____ **Date:** _____