Student Medical Information

This information is required to help us care for your child in times of illness or an emergency. If you indicate a condition a copy of this form may be displayed in the student's classroom, and in sickbay, along with a photograph of the student.

Student's Full Name: _____

Doctor: _____ Doctor's Phone No: _____

Medical Practice Name and Address: _____

If the student has (or has ever had) any of the following conditions please tick. **If yes**, indicate severity and **state medication required.** This form is to authorise a delegated school staff member to give my child their medication.

Condition		**Mild**	**Moderate**	**Severe**	**List details, medication required and provide supporting paperwork**
Asthma	Yes / No	☐	☐	☐	_____
Bee or Wasp Stings	Yes / No	☐	☐	☐	_____
Allergies/Epipen	Yes / No	☐	☐	☐	_____
Wears a Medic Alert	Yes / No				_____
Headaches/ Migraine	Yes / No	☐	☐	☐	_____
ADHD or ADD *(circle which)*	Yes / No	☐	☐	☐	_____
ASD or Autism	Yes / No	☐	☐	☐	_____
Diabetes	Yes / No	☐	☐	☐	_____
Physical Disability	Yes / No	☐	☐	☐	_____
Speech	Yes / No	☐	☐	☐	_____
Vision Loss	Yes / No	☐	☐	☐	Glasses or Contact Lenses *(circle which)* Yes / No
Hearing Loss	Yes / No	☐	☐	☐	Hearing Aid Yes / No
Epilepsy	Yes / No	☐	☐	☐	_____
If YES, when was last seizure?		_____			
Other Medical Conditions: *(specify)*	Yes / No	☐	☐	☐	_____
_____		☐	☐	☐	_____
_____		☐	☐	☐	_____
_____		☐	☐	☐	_____

Medication my child is currently taking (e.g. antibiotics), dosage, time to be taken:

_____ _____

_____ _____

☐ None of the above conditions apply to my child

Students Own Medication

All medications or drugs required for regular or emergency use are to be handed in to the school office. Medication must be provided in original pharmacy containers with the child's name and dosage instructions.

Permission to Give Panadol

Permission for Panadol to be given if required Yes / No *(please circle)*

If your child is given Panadol they will be given a note to take home, or you may be contacted if deemed necessary.

Declaration

I/We understand that the school does not have a Nurse or Registered Medical Practitioner to give medication; that the giving of the abovementioned medication will only be under the circumstances listed and according to the expressed written instructions given by the Parent/Guardian; that the school, in giving any medication, is acting responsibly and in the best interests of my child but is not responsible for any unforeseen circumstances.

Guardian/Parent's Signature: _____ Date: _____