Student Details

Surname _____ Given Names _____

_____ Date of Birth _____/_____/_____
day month year

Office use only

Year Level _____ House _____ Group _____

Address _____

_____ Postcode _____

Emergency Contact _____ Relationship to Student _____

Telephone _____ Mobile _____

Doctor's Name _____ Telephone _____

Private Health Fund (if any) _____ Fund No _____

Medical Conditions

Has or does your child suffer from any of the following, please tick.

Heart Condition	☐ Yes	☐ No	Bronchitis	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Homesickness	☐ Yes	☐ No	Phobias	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	ADD/ADHD	☐ Yes	☐ No	Bedwetting	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sleepwalking	☐ Yes	☐ No	Period Pain	☐ Yes	☐ No
Tonsilitis	☐ Yes	☐ No	Travel Sickness	☐ Yes	☐ No	Eyesight Difficulties	☐ Yes	☐ No
Sinuitis	☐ Yes	☐ No	Hayfever	☐ Yes	☐ No	Hearing Difficulties	☐ Yes	☐ No

Other, please specify _____

If yes to any of the above, please also provide details of treatment if applicable _____

_____

_____

Does your child take any medication on a daily basis? ☐ Yes ☐ No If yes, please specify.

Name of Medication _____ Dose _____ Time/s to be given _____

Permission to administer paracetamol (for fever, headaches, migraines, menstrual pain and minor injuries) ☐ Yes ☐ No

Signature of Parent or Guardian _____ Date _____

Is there any other type of medication your child may require while at the College or on school camps or excursions (eg. Naprogesic, Polaramine, Claratyne, Phenergan, Panadine, Nurofen, Aspirin etc). ☐ Yes ☐ No If yes, please provide details.

_____

Note: These medications must be supplied to the College to be kept in the medication cupboard. They need to be in the original pharmacy packaging with your child's name, dosage and times to be administered). If your child regularly uses paracetamol, please provide a supply to the school nurse.

Name of Medication _____ Dose _____ Time/s to be given _____

Permission for Medical Treatment. I hereby give permission for my child to be attended by a doctor or taken to a hospital if the supervising teacher considers it necessary. I hereby authorise the teacher in charge to permit my child to be given a blood transfusion, general anaesthetic and to be operated on in case of a medical emergency if such treatment is considered necessary by a qualified medical practioner during the period of my child's enrolment at West Moreton Anglican College.

Signature of Parent or Guardian _____ Date _____

Allergies

Is your child allergic to any of the following? If yes, please specify.

Medications ☐ Yes ☐ No _____

Insects ☐ Yes ☐ No _____

Bees/Wasps ☐ Yes ☐ No _____

Foods ☐ Yes ☐ No _____

Grasses ☐ Yes ☐ No _____

Bandaids/Tapes ☐ Yes ☐ No _____

Other, please specify _____

If yes to any of the above, please also provide details of treatment if applicable _____

_____

_____

Immunisation Record

Please fill in the below record and indicate next to each item the year/age of your child when they were last immunised.

Diptheria _____ Polio Sabin _____

Tetanus _____ HIB (Influenzae Type B) _____

Pertussis (Whooping Cough) _____ HEP A _____

Measles _____ HEP B _____

Mumps _____ Varicella (Chicken Pox) _____

Rubella _____ Other Immunisations, please specify _____

_____

Past Infectious Illnesses

Please indicate whether your son/daughter has had the following illnesses by responding Yes or No to each item.

Chicken Pox ☐ Yes ☐ No

Measles ☐ Yes ☐ No

Mumps ☐ Yes ☐ No

Glandular Fever ☐ Yes ☐ No

Scarlet Fever ☐ Yes ☐ No

Q-Fever ☐ Yes ☐ No

Rubella ☐ Yes ☐ No

Whooping Cough ☐ Yes ☐ No

Other Illnesses, please specify _____

_____

Is there anything else the College staff should know regarding the health and wellbeing of your child? Please specify _____

_____

_____

_____