

## CONFIDENTIAL MEDICAL INFORMATION

### For overseas, interstate and overnight camps and sleepovers



This information is intended to assist the College in case of any medical emergency involving your child. A copy of this information will be held by the College contact person and the originals will be held by the teacher coordinating the excursion. All information is held in confidence.

Student Name:															
Date of Birth:		Year Level:													
Address:															
Suburb:		P/Code:													
Parent/Guardian 1 Name:															
Work phone:		Mobile:													
Parent/Guardian 2 Name:															
Work phone:		Mobile:													
Name of Family Doctor:		Phone:													
Address:															
Medicare Card No.:		Expiry:													
Private Health Fund:		Member No.:													
Medical Condition(s):	<p>Please tick if your child suffers any of the following:</p> <table border="0"> <tr> <td><input type="checkbox"/> Anxiety disorder</td> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Bed wetting</td> <td><input type="checkbox"/> Blackouts</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Dizzy spells</td> <td><input type="checkbox"/> Fits of any type</td> <td><input type="checkbox"/> Heart condition</td> </tr> <tr> <td><input type="checkbox"/> Migraine</td> <td><input type="checkbox"/> SARS</td> <td><input type="checkbox"/> Sleepwalking</td> <td><input type="checkbox"/> Travel Sickness</td> </tr> </table> <p><input type="checkbox"/> Other (please elaborate): _____</p> <p>_____</p> <p>_____</p>			<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Fits of any type	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Migraine	<input type="checkbox"/> SARS	<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Travel Sickness
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Allergies:	<p>Does the student have any allergies? Please indicate below:</p> <p><input type="checkbox"/> Penicillin      <input type="checkbox"/> Other medications: _____</p> <p><input type="checkbox"/> Foods: _____</p> <p><input type="checkbox"/> Other: _____</p> <p>What special care is recommended?</p> <p>_____</p> <p>_____</p> <p>_____</p>														
Medical Management Plan (MMP):	<p>Is there a Medical Management Plan (MMP) in place?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If yes, does the school have a current copy of the MMP?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Does your child require any modifications to the plan?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>(if yes, please describe): _____</p> <p>_____</p> <p>_____</p> <p>If no, are you aware of any medical emergency that could arise? If yes, please provide details of the emergency and how to recognise it: _____</p> <p>_____</p> <p>_____</p> <p>Emergency Treatment: _____</p> <p>_____</p> <p>_____</p> <p>Please provide extra attachments if needed.</p>														

<b>Tetanus Immunisation:</b>	Year of last tetanus immunisation: <input style="width: 100px;" type="text"/> (Tetanus immunisation is normally given at five years of age (as Triple Antigen or CDT) and at fifteen years of age (as ADT)).
<b>Tablets/Medicines:</b>	Is your child presently taking any tablets and/or medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state name of medication, dosage etc: <hr/> <hr/> <hr/> <p>All medication containers must be labelled with your child's name, the dose to be taken, specific storage conditions, and when it should be taken.</p> <p>For customs processes (if applicable), you must enquire with your doctor as to whether it is necessary for your child to carry a letter from the doctor confirming that the medication is prescribed by a registered medical practitioner.</p> <p>If it is necessary or appropriate for your child to carry his or her own medication (for example, asthma puffers or insulin for diabetes), it must be with the knowledge and approval of both the teacher-in-charge and yourself.</p>
<b>Previous experience:</b>	Is this the first time your child has been away from home? <input type="checkbox"/> Yes <input type="checkbox"/> No

**CONSENT TO MEDICAL ATTENTION**

Where the teacher-in-charge of the excursion is unable to contact me, or it is otherwise impracticable to contact me, I authorise the teacher-in-charge, \_\_\_\_\_ (insert name) as my nominee to give consent to the appropriate medical or dental authorities for my child where such authorisation is required, eg. general anaesthetic, blood transfusion, etc. I give this consent on the understanding that the teacher-in-charge will, if at all possible, contact me by telephone prior to consenting to the administration of medical or dental treatment by the medical practitioner, dentist or hospital concerned. However, if the medical or dental practitioner considers that the medical or dental treatment should be administered immediately, and the teacher-in-charge is unable to contact me, I authorise:

- The teacher-in-charge to consent to the administration of medical or dental treatment
- The supervising staff to administer such first aid as the teacher-in-charge may judge to be reasonably necessary

In the event of illness or accident, *and in an emergency situation where an ambulance is not available within a reasonable period of time*, I consent to my child being transported to a hospital/medical/ dental clinic or to an ambulance by an excursion staff member in a school/private car.

I understand that in the event of illness or accident to my child, I will be responsible for all associated costs and charges, including ambulance transportation. It is a requirement of the College that students involved in overseas travel take out travel insurance. Please ensure that any documents relating to travel insurance are kept in a safe place.

<b>Signature of Parent/Guardian 1:</b> _____	<b>Date:</b> /    /
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<b>Signature of Parent/Guardian 2:</b> _____	<b>Date:</b> /    /
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