



## Student Health Record

PLEASE COMPLETE THE ENTIRE FORM IN BLOCK CAPITALS.

(Completion of this form is a requirement of the Application Process but does not guarantee a confirmed place)

Date Form Completed: ..... Student Year Level (at start): .....

### Family Information

Student's Surname: ..... Date of Birth: .....

Christian Name(s): (In full, underline preferred name) .....

### Medical Information

Doctor's Name: ..... Practice Phone No: .....

Practice Name: .....

Has the student been diagnosed with any of the following medical conditions? If Yes, please provide a current management plan.

Cardiac Conditions  Yes  No Medication: .....

Please provide nature of condition:

Diabetes (Type 1 or 2)  Yes  No Medication: .....

Epilepsy  Yes  No Medication: .....

Rheumatic Fever  Yes  No Medication: .....

Depression/Anxiety or other Mental Health Concerns

Yes  No Medication: .....

ADHD  Yes  No Medication: .....

Asthma  Yes  No Medication: .....

If Yes, is it  Mild  Moderate  Severe

Medication administered Daily: As required: .....

Please ensure the student has his spacer and inhaler at school to treat any acute asthma symptoms.

Does the student have any medical conditions not listed above (eg. Cancer, Bleeding Disorders)?

Yes  No Medication: .....

Please provide nature of condition: .....

#### Allergies and Reactions

Hayfever  Yes  No Medication: .....

If Yes, is it  Mild  Moderate  Severe

Significant allergic reactions

Yes  No Medication: .....

If Yes, to which  Stings  Medication  Food

If Yes, please list Allergen(s)

Reaction (eg rash, anaphylaxis).....

Does the student carry an EPIPEN for anaphylaxis?  Yes  No

**Students with anaphylaxis require an action plan and Health Centre staff must know EPIPEN location at school.**



Does the student suffer from any disability or condition not already outlined above?  
(eg migraines, arthritis, hearing, vision etc).

Yes  No

If Yes, please provide details: .....

Has the student ever been unwell with any of the following:

Chicken pox .....  Yes  No      Hepatitis B .....  Yes  No

HIV .....  Yes  No      Tuberculosis (TB) .....  Yes  No

Mumps .....  Yes  No      Glandular Fever .....  Yes  No

Please state any surgery the student has undergone (eg appendectomy, tonsillectomy etc):

Has the student previously suffered from a **serious concussion**?  Yes  No

If yes please provide details: .....

## Treatment

Do you agree to the student receiving any of the following medications/treatments if considered necessary by the Health Centre staff?

**If 'Yes' is not indicated, the Health Centre staff are not permitted to administer medication or refer to physio.**

Paracetamol .....  Yes  No      Antihistamine .....  Yes  No

Ibuprofen (anti-inflammatory) .....  Yes  No      Cough mixture .....  Yes  No

Natural anti-nausea (ginger tablets)....  Yes  No      Professional on-site physiotherapy...  Yes  No

## Vaccinations *Please supply a copy of the student's Immunisation Certificate. This is available from his doctor.*

**Has the student been fully immunised against:**

Diphtheria .....  Yes  No      Meningococcal B .....  Yes  No

Hepatitis B .....  Yes  No      Meningococcal ACWY .....  Yes  No

Pneumococcal .....  Yes  No      Haemophilus Influenza (Hib) .....  Yes  No

Rotavirus .....  Yes  No      Measles/Mumps/Rubella (MMR)...  Yes  No

Tuberculosis .....  Yes  No      Polio .....  Yes  No

Whooping Cough .....  Yes  No

Tetanus .....  Yes  No      Date of last Tetanus Injection .....

## Medication required at school must be left with the Nurse or Matron at the Health Centre.

The above medical or health information is requested in order to provide the Health Centre Staff and College with appropriate medical knowledge relating to the student. It will not be used for any other purpose. If the College is unable to make contact with those named as caregivers or as emergency contacts in an emergency, the College will seek appropriate medical assistance.

You are requested to sign this form giving permission, in case of an emergency, for this information to be passed on to a Doctor, Hospital or emergency staff. It also indicates your acceptance of the responsibility to reimburse the College for reasonable costs incurred.

If, in a medical emergency, the Health Centre or attending staff deem it necessary to call an ambulance to transfer the student to a medical facility, you will be responsible for the cost of the ambulance.

Signed (Parent/Guardian 1): ..... Date: .....

Signed (Parent/Guardian 2): ..... Date: .....

**Please return this form with your Application Form**

## Office use only:

Form checked by R/N.....  Yes      Date: .....