

MEDICAL INFORMATION AND CONSENT FORM

The Directorate collects the information contained in this form to provide or arrange first aid and other medical treatments for students. The information collected will be held at the student's school and will be made available to relevant school staff, including first aid officers, and to medical or paramedical staff in the case of an accident or emergency. The information contained in the form is personal information and it will be stored, used and disclosed in accordance with the requirements of the *Information Privacy Act 2014* and the *Health Records (Privacy and Access) Act 1997 (ACT)*.

Personal Details

Student's Name:		Date of Birth:		Gender:	<input type="checkbox"/> M <input type="checkbox"/> F
School:		School Year:		Camp/Excursion:	
Parent/Carer:					
Address:					
Business Hours:		After Hours:		Mobile:	
Emergency Contacts 1:				Telephone No:	
Emergency Contacts 2:				Telephone No:	
Name of Doctor:				Telephone No:	

Office Use Student central ID: _____ Entered into MAZE: <input type="checkbox"/> Date: _____

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Office Use Student central ID: _____ Entered into MAZE: <input type="checkbox"/> Date: _____

Please tick if your child suffers any of the following:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> blood pressure | <input type="checkbox"/> epilepsy* | <input type="checkbox"/> hay fever | <input type="checkbox"/> nose bleeds |
| <input type="checkbox"/> anaphylaxis* | <input type="checkbox"/> diabetes* | <input type="checkbox"/> fainting | <input type="checkbox"/> headaches | <input type="checkbox"/> reaction to drugs |
| <input type="checkbox"/> asthma* | <input type="checkbox"/> eczema | <input type="checkbox"/> fits or blackouts | <input type="checkbox"/> heart condition | <input type="checkbox"/> sight/hearing problems |
| <input type="checkbox"/> other (please specify) _____ | | | <input type="checkbox"/> sun screen sensitivity | |

*Please attach Emergency Treatment Plan/Action Plan

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Date of last tetanus injection:	
Is the student presently taking any medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Parents must give written permission and directions for the administration of any medication taken during school or after hours school activities. Medications are to be clearly labelled with prescription details, in unopened, original packaging. Completion of the <i>Emergency Treatment Plan</i> is required.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you aware of any physical or psychological limitations of your child? Please give details.	
Is there any other information which you believe may help us to provide the best possible care?	

Consent to medical attention

Parents/carers should note that in the absence of an *Emergency Treatment Plan*, in cases of emergency excepting anaphylaxis or asthma, only standard first aid will be administered. In an anaphylaxis or asthma emergency authorised medications; salbutamol (for the symptomatic treatment of asthma), and adrenaline (for the treatment of anaphylaxis) will be administered.

PLEASE READ: In the case of my child requiring medical treatment or in the case of a medical emergency, including an anaphylaxis and asthma emergency, I consent to the provision of first aid and any treatment as outlined in the attached *Emergency Treatment Plan*. I authorise the school, where it is impracticable to communicate with me, to arrange for my child to receive such medical or surgical treatment as may be deemed necessary. I undertake to pay any costs that may be incurred for the medical treatment, ambulance transportation and medications.

Signature..... Date.....

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- | | | | | |
|---|---|--|---|---|
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*Please attach *Emergency Treatment Plan/Action Plan*

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Are you aware of any physical or psychological limitations of your child? Please give details.	
Is there any other information you believe may help us to provide the care?	

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