

## ST LUKE'S GRAMMAR SCHOOL Student Medical History & Consent Form

### Confidentiality Disclaimer

The purpose of collecting the medical information outlined above is to enable St Luke's Grammar School to provide for educational, social, spiritual and medical wellbeing of the student. The information gathered enables the School to carry out its legal obligation relating to the discharge of duty of care. Health information about students is sensitive information within the terms of the National Privacy Precepts under the Privacy Act. From time to time, the School may disclose personal and sensitive information to others for administrative and educational purposes.

STUDENT DETAILS		
<b>Student's Last Name:</b>		
<b>Student's First Name:</b>		
Date of Birth:	School Year:	
<b>Mother's Name:</b>	Phone (H):	(W):
Email:	Mobile:	
Contact Preference ( <i>please circle</i> ): 1 <sup>st</sup> / 2 <sup>nd</sup>		
<b>Father's Name:</b>	Phone (H):	(W):
Email:	Mobile:	
Contact Preference ( <i>please circle</i> ): 1 <sup>st</sup> / 2 <sup>nd</sup>		
<b>Postal Address:</b>		
<b>Emergency and/or Guardian Name, Contact Numbers(s) If Parent Is Unavailable:</b>		
1. Name:	Relationship:	Phone:
2. Name:	Relationship:	Phone:
<b>Doctor (GP):</b>		Phone:
<b>Dentist:</b>		Phone:
<b>Orthodontist (if applicable):</b>		Phone:
Medicare No:	Expiry Date (MM/YY):	Position On Card:
Private Health Fund:	Membership No:	
ACKNOWLEDGEMENT OF DISCLOSURE & EMERGENCY TREATMENT PROCEDURE		
<p>We acknowledge that the information contained in this completed Student Medical History &amp; Consent form, provides full disclosure to the student's medical, physical, learning and / or psychological needs.</p> <p>In addition, in the event of an emergency we acknowledge that:</p> <ul style="list-style-type: none"> <li>the School will attempt to contact the parents and nominated Emergency Contact Person</li> <li>the School will call an ambulance or take the student to hospital or other medical centre (whichever is available)</li> <li>we accept responsibility for payment of any expenses thus incurred.</li> </ul>		
Name: _____ (parent/guardian)	Signed: _____	Date: _____
Name: _____ (parent/guardian)	Signed: _____	Date: _____

# ST LUKE'S GRAMMAR SCHOOL

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### 1. MEDICAL ALERT

1A Life Threatening Conditions	
Does the student have a life threatening condition: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> (If yes, detail below and complete the attached <b>Anaphylaxis</b> or <b>Asthma</b> Action Plan.)	
Details of the Life Threatening Condition(s):	
1B Asthma History	
Does the student suffer from Asthma? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No (go to Part 2)</span>	
If yes:	
Has the student been hospitalised due to Asthma in the past 2 years? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Has the student been treated with oral cortisone in the past 12 months? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Does the student have an Asthma Action Plan? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> (If yes, please enclose or complete attached <b>Asthma</b> Action Plan)	
Child's Current Reliever:	Current Preventer:
Other Medication Taken for Asthma?	

### 2. MEDICAL HISTORY

2A Medical Conditions
Please tick Yes or No below. (If Yes, please attach the Action Plan).
Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No    Dyslexia: <input type="checkbox"/> Yes <input type="checkbox"/> No    Epilepsy: <input type="checkbox"/> Yes <input type="checkbox"/> No    Other: <input type="checkbox"/> Yes <input type="checkbox"/> No
Please list other conditions the School should be aware of: (eg; Fainting, Hepatitis B Carrier, Incontinence, Special Needs or Disability, Learning Difficulties/Problems)
2B Hearing or Sight Difficulties
Please advise if the student has any Hearing or Sight difficulties: (eg; wears glasses etc)
2C Background Information
Is the student undergoing counselling outside of School? (If yes, please indicate if you have provided the School with a psychological report.)
Undergoing Counselling: <input type="checkbox"/> Yes <input type="checkbox"/> No      Psychological Report submitted: <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the student been diagnosed by a medical professional with:
<input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Depression <input type="checkbox"/> OCD
<input type="checkbox"/> Other (please include details below)

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### 3. CHILDHOOD DISEASES, OPERATIONS OR INJURIES

<b>3A Previous Childhood Diseases / Operations / Injuries</b>
Please list any previous Childhood Diseases / Operations / Injuries the School should be made aware of:
<b>3B Current Treatments</b>
Please list current treatments the School should be made aware of:

### 4. ALLERGIES

<b>4A Allergies and Treatment Required</b>		
Does the student have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please complete items below)		
<b>Allergic to:</b>	<b>Severe</b>	<b>Action Plan Attached</b>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has the student been hospitalised with severe allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the student have medication for allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If yes, please list medication prescribed):</p>		

### 5. WATER SAFETY

<b>5A Swimming Ability</b>
Can the student swim? <input type="checkbox"/> Yes <input type="checkbox"/> With a struggle <input type="checkbox"/> No
If yes, please indicate how far they can competently swim Freestyle <input type="checkbox"/> 50m <input type="checkbox"/> 100m <input type="checkbox"/> 200m <input type="checkbox"/> >200

### 6. OTHER

<b>6A. Please list any other additional information the School needs to know about your child:</b>

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### 7. IMMUNISATION HISTORY

7A Immunisation Status	
Is the student immunised?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, is the student:	<input type="checkbox"/> Fully Immunised <input type="checkbox"/> Partially Immunised
If yes, and the student is enrolled in the Junior School, please attach the <b>Immunisation History Statement</b> , or other documentation, as listed below.	
<b>NOTES FOR JUNIOR SCHOOL ENROLMENTS – Cottage through to Year 6</b> From 1 January 2014, changes to the Public Health Act 2010 mean preschools will not be able to enrol a child unless the parent/caregiver has provided documentation that shows that the child: <ul style="list-style-type: none"> <li>• is fully vaccinated for their age, (<b><i>please attach Immunisation History Statement</i></b>)</li> <li>• has a medical reason not to be vaccinated, or</li> <li>• has a parent/caregiver who has a conscientious objection to vaccination, or</li> <li>• is on a recognised catch-up schedule if their child has fallen behind with their vaccinations.</li> </ul>	
Parents can request an Immunisation History Statement by contacting the <b>Australian Childhood Immunisation Register</b> ( <a href="http://www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register?utm_id=9">http://www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register?utm_id=9</a> ) or calling 1800 653 809.	

### 8. MEDICATION

8A Prescription Medication		
Please list any prescription medication that the student is currently taking, including dosage and frequency:		
Medication	Dosage	Frequency

8B Authorised Medication	
Parents are requested to inform the School of any medications being taken by students and of any changes to medication. All medications taken during the school day should be stored in Student Reception unless other arrangements are made with the School. All medications administered by the School will be recorded.	
<b>Non-Prescription or 'Over-the-Counter' Medications</b> Due to new Department of Health Regulations (Pharmaceutical Branch) no medication may be given to students unless authorised and supplied as stated above by parents. Paracetamol (Panadol) tablets and Paracetamol (Panadol) mixture, will be held in Student Reception should it be required by the student. Any other medications will need to be supplied to Student Reception with the student's name and instructions for use. If you authorise us to administer Paracetamol tablets or Paracetamol mixture, to the student if required during the school day, please tick relevant box below and sign in the space provided.	
<input type="checkbox"/> Paracetamol _____ (please sign)	<input type="checkbox"/> Paracetamol Mixture: _____ (please sign)
Please list below any other non-prescription medications that the student may need and the name of the condition being treated. If the student requires these medications reasonably often (eg; migraine, allergy) please supply a small box of the medication to the School with the student's name and instructions as to dosage and frequency.	
Medication	Signature