HOLY ROSARY SCHOOL
DOUBLEVIEW
Foundations for Life

2017 MEDICAL INFORMATION FORM

Child's Name: _____ _____
(Christian Name) (Surname)

Year Level (2017) _____ Catherine / Dominic **Date of Birth**: ___/___/___

This form is to be completed by the **Parent or Guardian** of each student attending Holy Rosary Primary School. It is most important that this form be completed accurately and as comprehensively as possible.
Please tick the boxes below if your child has been diagnosed by a medical practitioner with one or more of the following conditions. There is space provided on the back of this form for you to write specific details and any other relevant information related to your child's particular medical needs. It is essential that a doctor provides a medical emergency plan if the condition is deemed very serious or life-threatening. Eg. anaphylactic reactions.

□ AD/HD	□ asthma	□ epilepsy	□ hearing problems	□ reaction to drugs
□ allergies Please state: □ peanut allergy □ egg allergy □ hayfever □Other: _____	□ blood pressure	□ fainting	□ heart condition	□ sight problems
	□ chlorine sensitivity	□ fits or blackouts	□ nose bleeds	□ sunscreen sensitivity
□ anaphylaxis - food - medicines - insect stings	□ diabetes	□ headaches	□ operations	□ travel sickness
□ anxiety	□ eczema	□ phobias	□ Other:	

Administering of Medication

1. It is expected that children on medication will have this administered at home.
2. If a child needs to receive any medication during school hours, either short-term or long term, a STUDENT MEDICATION REQUEST FORM must be completed; these are available from the Office.
3. Where medication must be administered at a *specific* time of the day, the parent / guardian is responsible for reminding their child and notifying relevant staff members to ensure the child presents at the Office at the correct time.
4. If your child has an EMERGENCY ACTION PLAN for a medical condition (e.g. anaphylaxis, asthma) parents/guardians are responsible for supplying the paperwork to the school and updating it as necessary, including medication that has expired.

Consent to Medical Attention

In the case of my child requiring medical treatment or in the case of a medical emergency, I consent to the school providing first aid treatment (or treatment as outlined in my child's EMERGENCY ACTION PLAN) and I further authorise the school, where they have been unable to contact me, to arrange for my child to receive such medical treatment as may be deemed necessary.
I give permission for my child to be driven to hospital by ambulance. I acknowledge that all costs incurred will become my responsibility.

Parent/Guardian's Signature:_____ **Date:**_____

Specific Details of My Child's Medical Needs - 2017

NAME OF CONDITION: _____

Is your child able to self medicate for this condition? Yes / No / Not applicable

Physical Symptoms

_____

Severity of condition _____

Medication required _____

Dosage _____ Frequency of dosage _____

Where medication is to be stored _____

Triggers for this condition _____

Emergency procedure (attach existing Emergency Action Plan from doctor or please provide one as soon as possible)

NAME OF CONDITION: _____

Able to self medicate for this condition? Yes / No / Not applicable

Physical Symptoms

_____

Severity of condition _____

Medication required _____

Dosage _____ Frequency of dosage _____

Where medication is to be stored _____

Triggers for this condition _____

Emergency procedure (attach existing Emergency Action Plan from doctor or please provide one as soon as possible)

IMPORTANT:

1. If you already have an existing **Emergency Action Plan as provided by your doctor** please **attach a copy** to this form, if not, then one must be obtained from your medical practitioner.

2. If your child had been seen by a health agency or professional, in the past 12 months, please list these below eg Speech Therapy; Psychologist; Occupational Therapy; Optometrist, Audiologist etc and provide any copies of REPORTS for our confidential files.