



Student Medical Information

Please ensure that the relevant questions on this form are completed.

SECTION A - STUDENT DETAILS

First name: _____ Family name: _____

Date of birth: ____ / ____ / ____

Doctor's name: _____ Doctor's phone: _____

All regional exchange students must carry their own Medicare card

Medicare number: _____ Number in family: ____ Card expiry date: ____ / ____

Health Care Card number: (if applicable) _____ Card expiry date: ____ / ____

Private medical and hospital benefits

Provider: _____ Membership number: _____

Level of cover: _____ Ambulance cover: Yes / No (Please circle)

Emergency Contact Details

Please list three emergency contacts if parents not available.

Name	Relationship	Home Phone	Work Phone	Mobile

Swimming Ability (Please circle)

CANNOT swim 50m comfortably - Can swim 50m COMFORTABLY - Can swim 50m STRONGLY

SECTION B - STUDENT IMMUNISATION DETAILS

Has your child been fully immunised against the following? Please circle Yes or No:

Measles/mumps/rubella (MMR)	Yes / No	Chicken pox	Yes / No
Gardasil (HPV)	Yes / No	Diphtheria, tetanus, pertussis (DTP)	Yes / No
Whooping cough	Yes / No	Polio	Yes / No
Meningococcal C	Yes / No	Flu vaccine	Yes / No
Tetanus, diphtheria (ADT)	Yes / No	Date of last ADT:	
Malaria	Yes / No	Hepatitis B	Yes / No
Other - please specify:			

SECTION C - MEDICAL CONDITIONS

Does your child suffer any medical condition? (Please circle) Yes / No

For example: allergies, asthma, diabetes, epilepsy, ADD or any other medical condition. Please list details:

Does your child suffer from any adverse reactions? (Please circle) Yes / No

For example: particular medicines, insect bites, food, etc. If yes, please list details below including characteristics of reaction e.g. skin rash and the treatment required:

Anaphylaxis students

To ensure that we adequately cater for anaphylaxis students we require parents to provide an anaphylaxis care plan. This information will be displayed in a prominent place in the student services office and online in the student's profile in TASS.

Anaphylaxis care plan included? (Please circle) Yes / NA

Does your child have a disability? (Please circle) Yes / No

For example: sight, hearing, speech impairment, etc. Please list details:

SECTION D - MEDICATIONS

Is your child taking any regular prescribed medication? (Please circle) Yes / No
 If yes, please complete details below:

Prescribed Medication	Schedule	Strength / Dose

In your view, is your child able to self-manage their medication and the school should consider that it is safe to do so? (Please circle) Yes / No

If your child needs to have medication administered during the school day, the medication may be left with the school’s student services office.

SECTION E - PARENT CONSENT FOR MEDICATIONS AND MEDICAL TREATMENT

Parent’s name: _____

Parent consent for prescribed medication

I consent to the school staff administering the prescribed medication listed above to my child as required. I also understand that it is not the responsibility of the school staff to follow up with the student.

Yes / No (Please circle)

Parent consent for non-prescribed medication

I consent to the school staff administering non-prescription medication to my child as required.

Yes / No (Please circle)

Parent consent for urgent medical treatment

I authorise the school staff to arrange urgent medical treatment (including general anaesthetic) for my child should the need arise. This consent will only be used if time constraints or circumstances prevent prior contact with the parent / guardian.

Yes / No (Please circle)

Parent / Guardian (signature) _____

Regarding confidentiality of this medical information, the Bishop Druitt College privacy policy can be obtained from our website or by request to the college.