

STUDENT MEDICAL DETAILS

MEDICAL CONDITION DETAILS:

Does the student suffer from any of the following impairments? (tick)	Hearing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Speech:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mobility:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the student suffer from Asthma? (tick) If No, please go to the Other Medical Conditions section					<input type="checkbox"/> Yes	<input type="checkbox"/> No

ASTHMA MEDICAL CONDITION DETAILS:

Answer the following questions **ONLY** if the student suffers from any asthma medical conditions.

Please indicate if the student suffers from any of the following symptoms: (tick) <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Wheeze <input type="checkbox"/> Exhibits symptoms after exertion <input type="checkbox"/> Tight Chest		If my child displays any of these symptoms please: (tick) Inform Doctor <input type="checkbox"/> Yes <input type="checkbox"/> No Inform Emergency Contact <input type="checkbox"/> Yes <input type="checkbox"/> No Administer Medication <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medical Action <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:	
Has an Asthma Management Plan been provided to School?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the student take medication? (tick) <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of medication taken:	
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)			<input type="checkbox"/> Preventative <input type="checkbox"/> Response
Indicate the usual dosage of medication taken:		Indicate how frequently the medication is taken:	
Medication is usually administered by: (tick) <input type="checkbox"/> Student <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Other			
Medication is stored: (tick) <input type="checkbox"/> with Student <input type="checkbox"/> with Nurse <input type="checkbox"/> Fridge in Staff Room <input type="checkbox"/> Elsewhere			
Dosage time		Reminder required? (tick) <input type="checkbox"/> Yes <input type="checkbox"/> No Poison Rating	

OTHER MEDICAL CONDITIONS

(More copies of the other medical condition forms are available on request from the school.)

Does the student have any other medical condition? (tick) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please specify:		
Symptoms:		
If my child displays any of the symptoms above please: (tick)		
Inform Doctor <input type="checkbox"/> Yes <input type="checkbox"/> No Administer Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Inform Emergency Contact <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medical Action <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:	
Does the student take medication? (tick) <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of medication taken:
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick) <input type="checkbox"/> Preventative <input type="checkbox"/> Response		
Indicate the usual dosage of medication taken:		Indicate how frequently the medication is taken:
Medication is usually administered by: (tick) <input type="checkbox"/> Student <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Other		
Medication is stored: (tick) <input type="checkbox"/> with Student <input type="checkbox"/> with Nurse <input type="checkbox"/> Fridge in Staff <input type="checkbox"/> Elsewhere		

				Room
Dosage time	Reminder required? (tick)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poison Rating

STUDENT DOCTOR DETAILS

The following details should **only** be provided if **this** student has a Doctor and/or Medicare number different to the Primary Family.

Doctor's Name:	
Individual or Group Practice: (tick)	<input type="checkbox"/> Individual <input type="checkbox"/> Group
No. & Street or PO Box No.:	
Suburb:	
State:	Postcode:
Telephone Number	Fax Number
Student Medicare Number:	

STUDENT EMERGENCY CONTACTS

This section should **ONLY** be filled out if **THIS** student has emergency contacts other than the Prime Family Emergency Contacts.

	<i>Name</i>	<i>Relationship</i> (Neighbour, Relative, Friend or Other)	<i>Language Spoken</i> (If English Write "E")	<i>Telephone Contact</i>
1				
2				

Thank you for taking the time to complete this Student Enrolment form. We understand that the information you have provided is confidential and will be treated as such, but the details are required to enable staff to properly enrol your child at our school.

<p>I certify that the information contained within this form is correct.</p> <p>Signature of Parent/Guardian: _____</p> <p>Date: ____ / ____ / ____</p>
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