

# GRACE LUTHERAN COLLEGE



## Confidential Student Medical History & Consent Form

### Confidentiality Disclaimer

The purpose of collecting the medical information outlined below is to enable Grace Lutheran College to provide for educational, social, spiritual and medical wellbeing of the student. The information gathered enables the College 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 Australian Privacy Principles under the Privacy Act 1988 and the Privacy Amendment (Enhancing Privacy Protection) Act 2012. From time to time, the School may disclose personal and sensitive information to others for administrative, financial, health and educational purposes. If you require access to your student's personal information or you do not agree to personal information being obtained or shared to relevant organisations/medical practitioners, please contact the Principal in writing. For further information on privacy ([Privacy Act - Standard Collection Notice](#)), please visit our website.

STUDENT DETAILS		
<b>Student's Last Name:</b>		<b>Student's First Name:</b>
Date of Birth:	Year Level:	Year:
<b>Mother/Guardian's Name:</b>	Ph (H):	(W):
Email:	Mobile:	
<b>Address:</b>		
<b>Father/Guardian's Name:</b>	Ph (H):	(W):
Email:	Mobile:	
<b>Address:</b>		
<b>Student lives with:</b>		
<b>Emergency and/or Guardian Name, Contact Numbers if Parent Is Unavailable:</b>		
1. Name:	Relationship:	Ph:
2. Name:	Relationship:	Ph:
<b>Medicare No:</b>	Expiry Date (MM/YY):	Position On Card:
<b>Private Health Fund:</b>	Membership No:	Position On Card:
<b>Hospital Preference:</b>		
<b>Doctor (GP):</b>	Ph:	
<b>Dentist:</b>	Ph:	
<b>Orthodontist (if applicable):</b>	Ph:	
<b>ACKNOWLEDGEMENT OF DISCLOSURE &amp; EMERGENCY TREATMENT PROCEDURE</b>		
We acknowledge that the information contained in this completed Student Medical History & Consent Form provides full disclosure to the student's medical, physical, learning and / or psychological needs.		
In addition, in the event of an emergency we acknowledge that: (please tick)		
<input type="checkbox"/> the College will attempt to contact the parents and nominated Emergency Contact Person		
<input type="checkbox"/> the College will call an ambulance to take the student to hospital		
<input type="checkbox"/> we give the College permission to approve emergency treatment		
<input type="checkbox"/> we <b>agree / disagree</b> to emergency blood transfusion ( <i>strike out which does not apply</i> )		
Name: _____	Signed: _____	Date: _____
<i>(parent/guardian)</i>		
Name: _____	Signed: _____	Date: _____
<i>(parent/guardian)</i>		

## IMMUNISATION HISTORY

Immunisation Status			
Please indicate if the following immunisations are up to date:			
	<b>Yes</b>	<b>No</b>	
HIB (Haemophilus Influenzae Type B)	<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	H1N1 (Swine Flu)
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus
HPV (Human Papillomavirus)	<input type="checkbox"/>	<input type="checkbox"/>	DTP (Triple Antigen)
MMR (Measles/Mumps/Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	Varicella Chicken Pox
Meningococcal C	<input type="checkbox"/>	<input type="checkbox"/>	
Parents can request an Immunisation History Statement by contacting the Australian Childhood Immunisation Register <a href="https://www.humanservices.gov.au/customer/services/medicare/australian-immunisation-register">https://www.humanservices.gov.au/customer/services/medicare/australian-immunisation-register</a> or calling 1800 653 809.			

## MEDICATION

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

Authorised Medication										
<p>Parents/Guardians are requested to inform the College of any medications being taken by students and of any changes to medication. All medications taken during the school day should be stored at the Health Centre unless other arrangements are made. All medications administered by the College will be recorded and will need a Medication Consent Form completed.</p> <p><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 will be held in the Health Centre should it be required by the student. Any other medications will need to be supplied to the Health Centre with the student's name and instructions for use. If you authorise the College to administer Over the Counter Medications during the school day, please tick relevant box below and sign in the space provided.</p> <p><input type="checkbox"/> Paracetamol (eg: Panadol) 500mg or 1g as required (please sign) _____</p> <p><input type="checkbox"/> Antihistamine (eg: Zyrtec, Claratyne, Telfast) (please sign) _____</p> <p><input type="checkbox"/> Ibuprofen (eg: Nurofen) 200mg or 400mg as required (please sign) _____</p> <p>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 Health Centre with the student's name and instructions as to dosage and frequency.</p>										
<table border="1"> <thead> <tr> <th>Medication</th> <th>Signature</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Medication	Signature								
Medication	Signature									

**MEDICAL ALERT**

*\*\* (Action Plan Templates are available from the College Website – Rothwell Campus – Health Centre page)*

<b>Anaphylaxis</b>	
Does the student have Anaphylaxis: <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, detail below and attach the Action Plan.)</i>	
Details of Anaphylaxis:	
<b>Asthma</b>	
Does the student suffer from Asthma: <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, detail below and attach the Action Plan.)</i>	
<b>Asthma History:</b>	
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>	
Student's Current Reliever:	Current Preventer:
Other Medication Taken for Asthma?	
Details of Asthma:	
<b>Diabetes</b>	
Does the student have Diabetes: <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, detail below and attach the Action Plan.)</i>	
Details of Diabetes:	
<b>Epilepsy</b>	
Does the student have Epilepsy: <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, detail below and attach the Action Plan.)</i>	
Details of Epilepsy:	
<b>Other Life Threatening Condition</b>	
Does the student have a life threatening condition: <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, detail below and attach the Action Plan.)</i>	
Details of the Life Threatening Condition(s):	

**ALLERGIES**

<b>Allergies and Treatment Required</b>		
Does the student have any Allergies: <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, please complete items below)</i>		
<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
Has the student been hospitalised with severe allergy? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Does the student have medication for allergy <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, please list medication prescribed)</i>		

## MEDICAL CONDITIONS

Please list other conditions the College should be aware of:

(eg: Fainting, Hepatitis B Carrier, Incontinence, Special Needs or Disability, Learning Difficulties)

## FOOD INTOLERANCES

Please list any Food Intolerances:

(eg: Gluten, Wheat, Dairy, Lactose etc)

## MEDICAL HISTORY

### Hearing or Sight Difficulties

Please advise if the student has any Hearing or Sight difficulties:

### Background Information

Is the student undergoing counselling outside of School?

(If yes, please indicate if you have provided the College with a psychological report.)

Undergoing Counselling:  Yes  No      Psychological Report submitted:  Yes  No

Has the student been diagnosed by a medical professional with:

Anxiety       ADHD       Autism       Depression       OCD  
 Other (please include details)  N/A

### Previous Childhood Diseases / Injuries

Please list any previous childhood diseases / injuries the College should be made aware of:

### Previous Operations

Please list any previous operations the College should be made aware of:

### Current Treatments

Please list current treatments the College should be made aware of:

## WATER SAFETY

### Swimming Ability

Can the student swim:  Yes  No

Ability Level:  Advanced       Intermediate       Beginner       Non-Swimmer

## OTHER

Please list any other additional information the College needs to know about your child: