GRACE LUTHERAN COLLEGE

Confidential Student Medical History & Consent Form

Confidentiality Disclaimer

The purpose of collecting the medical information outlined above 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, 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		
Student's Last Name:	**Student's First Name:**	
Date of Birth:	Year Level:	Year:
Mother/Guardian's Name:	Ph (H):	(W):
Email:	Mobile:	
Address:		
Father/Guardian's Name:	Ph (H):	(W):
Email:	Mobile:	
Address:		
Student lives with:		
Emergency and/or Guardian Name, Contact Numbers if Parent Is Unavailable:		
1. Name:	Relationship:	Ph:
2. Name:	Relationship:	Ph:

Medicare No:	Expiry Date (MM/YY):	Position On Card:
Private Health Fund:	Membership No:	Position On Card:
Hospital Preference:		
Doctor (GP):		Ph:
Dentist:		Ph:
Orthodontist (*if applicable*):		Ph:

ACKNOWLEGEMENT OF DISCLOSURE & EMERGENCY TREATMENT PROCEDURE

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:

- ☐ the College will attempt to contact the parents and nominated Emergency Contact Person
- ☐ the College will call an ambulance to take the student to hospital
- ☐ we give the College permission to approve emergency treatment
- ☐ we **agree / disagree** to emergency blood transfusion ***(strike out which does not apply)***

Name: _____ Signed: _____ Date: _____
(parent/guardian)

Name: _____ Signed: _____ Date: _____
(parent/guardian)

IMMUNISATION HISTORY

Immunisation Status					
Please indicate if the following immunisations are up to date:					
	Yes	No		Yes	No
HIB (Haemophilus Influenzae Type B)	☐	☐	Poliomyelitis	☐	☐
Hepatitis A	☐	☐	H1N1 (Swine Flu)	☐	☐
Hepatitis B	☐	☐	Tetanus	☐	☐
HPV (Human Papillomavirus)	☐	☐	DTP (Triple Antigen)	☐	☐
MMR (Measles/Mumps/Rubella)	☐	☐	Varicella Chicken Pox	☐	☐
Meningococcal C	☐	☐			

Parents can request an Immunisation History Statement by contacting the Australian Childhood Immunisation Register https://www.humanservices.gov.au/customer/services/medicare/australian-immunisation-register 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

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.

Non-Prescription or 'Over-the-Counter' Medications

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.

☐ Paracetamol (eg: Panadol) 500mg or 1g as required (please sign) _____

☐ Antihistamine (eg: Zyrtec, Claratyne, Telfast) (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 Health Centre with the student's name and instructions as to dosage and frequency.

Medication	Signature

MEDICAL ALERT

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

Anaphylaxis	
Does the student have Anaphylaxis: *(If yes, detail below and attach the Action Plan.)*	☐ Yes ☐ No
Details of Anaphylaxis:	

Asthma	
Does the student suffer from Asthma: *(If yes, detail below and attach the Action Plan.)*	☐ Yes ☐ No
Asthma History:	
Has the student been hospitalised due to Asthma in the past 2 years?	☐ Yes ☐ No
Has the student been treated with oral cortisone in the past 12 months?	☐ Yes ☐ No
Does the student have an Asthma Action Plan?	☐ Yes ☐ No
Student's Current Reliever:	Current Preventer:
Other Medication Taken for Asthma?	
Details of Ashtma:	

Diabetes	
Does the student have Diabetes: *(If yes, detail below and attach the Action Plan.)*	☐ Yes ☐ No
Details of Diabetes:	

Epilepsy	
Does the student have Epilepsy: *(If yes, detail below and attach the Action Plan.)*	☐ Yes ☐ No
Details of Epilepsy:	

Other Life Threatening Condition	
Does the student have a life threatening condition: *(If yes, detail below and attach the Action Plan.)*	☐ Yes ☐ No
Details of the Life Threatening Condition(s):	

ALLERGIES

Allergies and Treatment Required			
Does the student have any Allergies: ☐ Yes ☐ No *(If yes, please complete items below)*			
Allergic To:	**Severe**	**Action Plan Attached**	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
Has the student been hospitalised with severe allergy? ☐ Yes ☐ No Does the student have medication for allergy ☐ Yes ☐ No *(If yes, please list medication prescribed)*			

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: