

**CLEVE AREA SCHOOL STUDENT MEDICAL AND HEALTH INFORMATION (YEAR 2016)**

STUDENT'S SURNAME \_\_\_\_\_ GIVEN NAMES \_\_\_\_\_ D.O.B. \_\_\_\_\_

STUDENT'S MOBILE PHONE \_\_\_\_\_ . YEAR LEVEL: \_\_\_\_\_

PARENT/GUARDIAN NAMES \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK (1) \_\_\_\_\_ (2) \_\_\_\_\_

MOBILE(1) \_\_\_\_\_ (2) \_\_\_\_\_

**EMERGENCY CONTACT IF YOU ARE NOT AVAILABLE** UHF CHANNEL \_\_\_\_\_

NAME \_\_\_\_\_ HOME \_\_\_\_\_ MOBILE \_\_\_\_\_

If your child becomes ill or is injured while at school, staff will administer first aid and call an ambulance if necessary. Ambulance call out costs are the responsibility of the parents.

AMBULANCE MEMBERSHIP NUMBER \_\_\_\_\_ EXPIRY DATE \_\_\_\_\_

Please complete the following information:

**MEDICAL CONDITION(S)**

Does this student have any medical condition or health problem that might affect them?: (PLEASE CIRCLE)

- In the classroom YES/NO
- During physical education & sport YES/NO
- During camps, aquatics, other activities YES/NO

**EXAMPLES:**  
Allergies, Diabetes, Asthma, Convulsions,  
Other chest problems, Seizures, Vision, Hearing

If you have answered "Yes" to any of the above:

What is the nature of the condition? If Asthma, please complete <b>ASTHMA CARE PLAN (attached)</b>
How could it affect the student?
What treatment is required?

**MEDICAL EMERGENCIES**

Are you aware of any possible medical emergencies that could affect this student. YES / NO (PLEASE CIRCLE)  
If you have answered "Yes" complete the following:

**INDIVIDUAL EMERGENCY HEALTH PLAN (available from the school if necessary)**

What is the emergency?
How do we recognise the emergency?
How can it be prevented/avoided?
Has the child's Doctor indicated how it should be treated at school?

MEDIC ALERT NUMBER: \_\_\_\_\_ MEDICARE NUMBER: \_\_\_\_\_ ( ) EXP: \_\_\_\_\_

**MEDICATIONS**

Is it necessary for this student to take medication at school for a medical condition? YES / NO (PLEASE CIRCLE)  
If you have answered "YES", please supply a **MEDICATION PLAN**, from the school or Doctor, and send the medication to school in the original container, showing the label from the Pharmacy.

**IF YOUR CHILD HAS A KNOWN BEESTING ALLERGY – PLEASE SUPPLY THE SCHOOL WITH A MEDICATION PLAN FROM THE DOCTOR AND TABLETS.**

**SPECIAL AIDS**

Does this student need to use any special aids at school? (EXAMPLE: Glasses, hearing aids, etc.) YES / NO If "Yes" give details: _____
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SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ Date \_\_\_\_\_