CLEVE AREA SCHOOL STUDENT MEDICAL AND HEALTH INFORMATION (YEAR 2019)

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**	**EXAMPLES:**
During physical education & sport	**YES/NO**	Allergies, Diabetes, Asthma, Convulsions,
During camps, aquatics, other activities	**YES/NO**	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 ***ASTHMA CARE PLAN*** (**attached)**
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:_____

SIGNATURE OF PARENT/GUARDIAN_____ Date _____