CLEVE AREA SCHOOL

Eyre Peninsula, South Australia

Second Street, Cleve South Australia 5640
Phone: (08) 86282104 Fax: (08) 86282511
Email:dl.0753_info@schools.sa.edu.au

Medical and Health Information 2021

Child's Name: _____ Class Teacher: _____

PARENTS / CAREGIVER NAMES: _____

ADDRESS: _____PHONE NO: _____

PARENT/GUARDIAN NAMES: _____
HOME PHONE: _____ WORK (1) _____ (2) _____

MOBILE: (1) _____ (2) _____

UHF CHANNEL _____

EMERGENCY CONTACT IF YOU ARE NOT AVAILABLE

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:_____

CLEVE AREA SCHOOL

Eyre Peninsula, South Australia

Second Street, Cleve South Australia 5640
Phone: (08) 86282104 Fax: (08) 86282511
Email:dl.0753_info@schools.sa.edu.au

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:_____

Parent / Caregiver Signature: _____ Date: _____