Immaculate Heart College

Through Mary to Jesus: "The Way, the Truth and the Life"
John 14:6

Confidential Student Medical History & Consent Form

Confidentiality Disclaimer
The purpose of collecting the medical information outlined above is to enable Immaculate Heart College to provide for educational, social 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 Agreement (Enhancing Privacy Protection) Act 2012. From time to time, the College may disclose personal and sensitive information to others for administrative, health and educational purposes. If you require access to your child'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.

STUDENT DETAILS		
Student Surname:	Student First Name:	
Date of Birth:	Year Level:	Year:
Mother/Carer's Name:	Ph (H):	(W):
Email:	Mobile:	
Address:		
Father/Carer'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:	

ACKNOWLEDGEMENT 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/carer)

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

MEDICATION

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

Authorised Medication
Parent/Carers 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 students. 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 the relevant box below and sign in the space provided. ☐ Paracetamol (eg. Panadol) 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**

ALLERGIES

ALLERGIES AND Treatment Required		
Does the student have 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 the allergy? ☐ Yes ☐ No *(If yes, please list medication prescribed)*		

MEDICAL ALERT

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

Asthma		
Does the student have 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 Asthma:		

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 Life-Threatening Condition(s):		

MEDICAL CONDITIONS

Please list any other conditions
(eg. Fainting, Hepatitis B Carrier, Incontinence, Special Needs or Disability, Learning Difficulties etc)

FOOD INTOLERANCES

Please list any Food Intolerances
(eg. Gluten, Wheat, Dairy, Lactose etc.)

MEDICAL HISTORY

Hearing or Sight Difficulties
Please advise if the students 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)
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: