Medical Information Form

Year ________ Name ____________________________ D.O.B. ____/____/____

Medical Practitioner

G.P. ____________________________________ Phone No. ________________

Address ____

Specialist/s

1. Name ____________________________________ Phone No. ________________

   Address ____

2. Name ____________________________________ Phone No. ________________

   Address ____

3. Name ____________________________________ Phone No. ________________

   Address ____

In the event that the school is unable to contact parents, it may be necessary to call an ambulance or, for less urgent medical attention, the Kenmore Family Medical Practice would be consulted. In the latter case, provision of Medicare number and Health Care Card number (if applicable) would be required.

Medicare No. __________________Expiry Date ___/___ Health Care Card No. ________________ Expiry Date ___/___

Requirements concerning Medication at school

I request that the following medication be administered by a staff member at school. I also undertake to advise the school within 24 hours of any change in medication dosage or administration.

Signature (Parent/Guardian) ________________________________ Date _____/_____/_____

Medication ____

____

____

____

Please read the following information:

When the administration of medicine is required, the staff are happy to do this at your request as part of their goodwill. There is no legal obligation to do this. Thus, in accordance with safe practices, the prescribed dosage and procedure advice ***must*** be clearly stated in writing directly by the Medical Practitioner or clearly marked by the Pharmacist on the medication container itself. This includes medication such as Panadol, vitamin and herbal tablets. In the case of vitamin and herbal tablets, a letter from a registered naturopath or homeopath with details of dosage and times may also be accepted. A parent's signature ***must*** be provided in all cases.

Specific conditions with respect to asthma treatment and use of nebulizers exist. The school has been advised that Nebulizers may not be administered by teachers, aides or any other people not qualified to use them. The only persons on staff at this school who would be qualified to administer the nebulizer are the physiotherapists, and this is only on detailed written advice from the child's medical practitioner. If the administration of the Nebulizer on a regular daily basis would involve a substantial time commitment, thereby taking the therapist away from other duties, it will be necessary for parents to attend the school for administering the Nebulizer themselves.

These restrictions on the administration of medication and associated procedures follow Education Queensland Policy and Guidelines.

Section A: **Does your child suffer or has your child suffered from any of the following? (if YES, please give details of current management)**

Rheumatic Fever No [ ] Yes [ ] ______

Diabetes No [ ] Yes [ ] ______

Heart Disease No [ ] Yes [ ] ______

Blood Pressure No [ ] Yes [ ] ______

Asthma &/or Respiratory Disease No [ ] Yes [ ] ______

Epilepsy No [ ] Yes [ ] ______

Kidney Disease No [ ] Yes [ ] ______

Anaphylaxis No [ ] Yes [ ] ______

Known Allergies/Intolerance (e.g. insect)
No [ ] Yes [ ] ______

Known Food Allergies/Intolerance (e.g. dairy)
No [ ] Yes [ ] ______

Has your child had any other illness or operations? No [ ]
Yes [ ] ______

Does your child experience excessive bleeding after a cut or tooth extraction? No [ ]
Yes [ ] ______

Section B: **Specific action required in an emergency. (Letter from Doctor to be attached to this form if appropriate)**

Section C: Immunization

Queensland schedule for children born prior to 1st May 2000.

Please tick if the following have been given:

Triple Antigen (diphtheria, tetanus, whooping cough)	2mths [ ]	4mths [ ]	6mths [ ]	18mths [ ]
Triple Antigen and Sabine	5yrs [ ]			
Hib	2mths [ ]	4mths [ ]	6mths [ ]	18mths [ ]
Sabine Polio	2mths [ ]	4mths [ ]	6mths [ ]	18mths [ ]
Measles, Mumps, Rubella	12mths [ ]	Booster 10-13yrs [ ]		
Hep B	[ ]			
Tetanus Injection (if this has been needed since triple antigen at age 5)	[ ]			

New schedule for children born on or after 1 May 2000 in SA, NSW, QLD, ACT and NT.

Please tick if the following have been given:

Age	Disease	Vaccine	
Birth	Hepatitis B	HBV	[ ]
2 months	Diphtheria, tetanus, pertussis & hepatitis B	DTPa-hepB	[ ]
	Hib	Hib vaccine	[ ]
	Poliomyelitis	OPV	[ ]
4 months	Diphtheria, tetanus, pertussis & hepatitis B	DTPa-hepB	[ ]
	Hib	Hib vaccine	[ ]
	Poliomyelitis	OPV	[ ]
6 months	Diphtheria, tetanus, pertussis & hepatitis B	DTPa-hepB	[ ]
	Poliomyelitis	OPV	[ ]
12 months	Measles, mumps & rubella	MMR	[ ]
	Hib	Hib vaccine	[ ]
18 months	Diphtheria, tetanus and pertussis	DTPa	[ ]
4 years	Diphtheria, tetanus and pertussis	DTPa	[ ]
	Measles, mumps & rubella	MMR	[ ]
	Poliomyelitis	OPV	[ ]

New schedule for children born on or after 1 May 2000 in VIC, WA and TAS.

Please tick if the following have been given:

Age	Disease	Vaccine	
Birth	Hepatitis B	HBV	[ ]
2 months	Diphtheria, tetanus and pertussis	DTPa	[ ]
	Hib and hepatitis B	Hib-hepB	[ ]
	Poliomyelitis	OPV	[ ]
4 months	Diphtheria, tetanus and pertussis	DTPa	[ ]
	Hib and hepatitis B	Hib-hepB	[ ]
	Poliomyelitis	OPV	[ ]
6 months	Diphtheria, tetanus and pertussis	DTPa	[ ]
	Poliomyelitis	OPV	[ ]
12 months	Measles, mumps & rubella	MMR	[ ]
	Hib and hepatitis B	Hib-hepB	[ ]
18 months	Diphtheria, tetanus and pertussis	DTPa	[ ]
4 years	Diphtheria, tetanus and pertussis	DTPa	[ ]
	Measles, mumps & rubella	MMR	[ ]
	Poliomyelitis	OPV	[ ]

Section D: Hearing/Vision Information

Hearing Tests	**Vision Tests**
Has your child had a hearing test? Yes [ ] No [ ] Date of hearing test/s ________________ Results of last hearing test Normal [ ] Other [ ] (please attach copy of test results)	Has your child had a vision test? Yes [ ] No [ ] Date of vision test/s ________________ Results of last hearing test Normal [ ] Other [ ] (please attach copy of test results)

Section E: Special Dietary Requirements

Food Items	**Substitutes** (if applicable)