KENNEDY STATE SCHOOL - STUDENT MEDICAL FORM

To be completed by Parent/Guardian of all students participating in excursions, camps or sporting activities

1. STUDENT DETAILS

Name of student:	Date of Birth:
Excursion/camp/sporting activity:	Date/s:
Emergency Contact Name and Phone Number:	

2. MEDICAL CONDITIONS

Please indicate below any known medical conditions relevant to the above name student. In those instances where there is "YES" response, please describe the nature of the problem or provide a letter from your doctor.

Medical Condition	**Response**	**Additional Comments**
Heart Problems	□ Yes □ No	
Blood Pressure	□ Yes □ No	
Respiratory Problems (other than Asthma)	□ Yes □ No	
Asthma	□ Yes □ No	
Epilepsy	□ Yes □ No	
Operations	□ Yes □ No	
Allergies (including diet)	□ Yes □ No	
Drug Reactions	□ Yes □ No	
Recent Illness	□ Yes □ No	
Phobias	□ Yes □ No	
Bed-wetting	□ Yes □ No	
Other (eg. travel sickness)	□ Yes □ No	
Date of most recent Tetanus injections		

3. CURRENT PRESCRIBED MEDICATION(S)

The medication(s) listed below has/have been prescribed for my child by a registered medical practitioner and will be required to be administered while my child is involved in the activity indicated in Section 1. I understand that all unused medication(s) will be returned to me.

a) Does the school have written permission for the student to administer own medication? □ **Yes** □ **No**

b) Does the school have current written permission to administer medication(s) to student? □ **Yes** □ **No**

c) I hereby request the teacher/staff member accompanying the activity, who have been so authorised by the Principal, to administer the medication(s) in accordance with the instructions written on the medication container(s) by the pharmacist in accordance with the medical practitioners instructions. □ **Yes** □ **No**

Name of Medication	Dose of Medication	Times to be Administered

4. MEDICAL PRACTITIONER AND HEALTH FUND

Name of family doctor:		Phone:
Address:		
Medicare No:	Private Health fund:	Membership No:

I hereby authorise the medical practitioner identified in Section 4 to provide to hospital authorities or other qualified practitioners additional information concerning any of the medical conditions identified in Section 2 should such need arise.

I understand that in a medical emergency the Queensland Ambulance may be required to assist my child. □ **Yes** □ **No**

Signature of Parent/Guardian: ____ Date: __________

The information collected on this form is being obtained for the purpose of supporting your child in the event of a medical emergency. The information will be stored securely. You may access or correct personal information provided by contacting the school. If you have a concern about the way your personal information has been collected, stored, used or disclosed you may contact the school in the first instance.