Name: .....

Class: .....

Parent Signature: .....

REDLANDS COLLEGE

OFFICE USE ONLY

Date Received: .....

Date Entered: .....

REDLANDS COLLEGE

Medical Details Form

Please ensure that this form is filled out correctly and returned to the school office prior to your child starting for the school year.

In the interests of your childs welfare we ask that you complete this form. The information provided by you in this document will be treated as strictly confidential and will only be shared with the relevant staff members when necessary.

The school suggests that you retain a copy of this form for your records. Please fill out this form as completely as possible as this would assist us in the event of a medical emergency. Should you have any changes to your child's details, please inform the school in writing.

REDLANDS COLLEGE
38 Anson Road
WELLINGTON POINT QLD 4160. .
Phone: 07 3286 0222 Fax: 07 3207 3799
mail@redlands.qld.edu.au
ABN: 66 822 314 686

Student Information

*** Denotes a required field**

Family Name: _____

Given Name(s): _____

Preferred Name *: _____

Date of Birth *: _____

Religion: _____

Boarder: Yes / No (Please circle)

Medical / Other Information

Panadol Perm.: Yes / No (Please circle)

Glasses/Contacts: Yes / No (Please circle)

Medicare Number/Pos: _____

Medicare Exp. MM/YY: _____

Medical Practitioners

Dentist _____ **Phone:** _____

Doctor _____ **Phone:** _____

General Practice _____ **Phone:** _____

Specialist _____ **Phone:** _____

Immunisations (Past 12 months)

Swimming Ability

Please select the most accurate description of your child's swimming ability.

☐ Confident Swimmer

☐ Fair Swimmer

☐ Non Swimmer

Other Current Medication

Medication (e.g. Multivitamins)	Method (e.g. orally)	Details

Supplementary Information

Does your child require any of the following items? If answering 'Yes' please provide your child with the necessary items.

Asthma Medication: Yes / No (Please circle)

Diabetes Pack: Yes / No (Please circle)

EpiPen: Yes / No (Please circle)

Health Plan: Yes / No (Please circle)

Hearing Assistance: Yes / No (Please circle)

Medication Request: Yes / No (Please circle)

Medication -Sick Bay: Yes / No (Please circle)

I hereby acknowledge that the information provided is accurate.

Signature of Parent / Guardian (Please circle) _____

Please print your name _____ Date ____/____/____

Appendix A: Medical Conditions

ADD/ADHD	Yes / No (Please circle)	Medication: _____
Allergy	Yes / No (Please circle)	Food Allergy: _____ Drug/Ointment Allergy: _____ Other: _____ Additional Details: _____
Anaphylaxis	Yes / No (Please circle)	EpiPen Expiry Date: _____ Current Action Plan supplied: _____ Antihistamine Dosage: _____ Additional Details: _____
Asthma	Yes / No (Please circle)	If 'Yes', please complete APPENDIX B: Asthma Management Plan. This form must be completed and signed by your doctor. Supplied Management Plan?: _____
Behaviour/Learning Condition	Yes / No (Please circle)	Additional details: _____
Cardiac/Heart Conditions	Yes / No (Please circle)	Additional details: _____
Diabetes	Yes / No (Please circle)	Supplied Management Plan?: _____
Eczema	Yes / No (Please circle)	Additional details: _____
Epilepsy/Seizures	Yes / No (Please circle)	Triggers: _____ Supplied Management Plan?: _____ Additional Details: _____

Food Intolerance	Yes / No (Please circle)	Additional details: _____
Hayfever	Yes / No (Please circle)	Additional details: _____
Headache/Migraine	Yes / No (Please circle)	Additional details: _____
Hearing	Yes / No (Please circle)	Additional details: _____
Other Condition	Yes / No (Please circle)	Additional details: _____
Period Pain	Yes / No (Please circle)	Additional details: _____
Recent Injury/Illness	Yes / No (Please circle)	Additional details: _____
Recent Operation	Yes / No (Please circle)	Additional details: _____
Travel Sickness	Yes / No (Please circle)	Additional details: _____
Vision	Yes / No (Please circle)	Colour Blind: _____

CONFIDENTIAL
Appendix B: Asthma Management Plan

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner).
Parents/carers should inform the school immediately if there are any changes to the management plan.
Please tick the appropriate box and print your answers clearly in the blank spaces where indicated.

Student's Name: _____ **Age:** _____

Date of Birth: _____ **Form/Class:** _____ **Gender:** _____

Emergency Contact: _____

Home Ph: _____ **Work Ph:** _____

Mobile 1: _____ **Mobile 2:** _____

Doctor Name: _____ **Phone(BH):** _____ **Mobile/Pager:** _____

Ambulance Sub: Yes / No (Please circle) **Subscriber No:** # _____ **Medicare No:** # _____

Usual signs of student's asthma	**Worsening signs**	**Triggers**
Wheezing ☐	Wheezing ☐	Exercise ☐
Tightness in chest ☐	Tightness in chest ☐	Colds/Viruses ☐
Coughing ☐	Coughing ☐	Pollens ☐
Difficulty breathing ☐	Difficulty breathing ☐	Dust ☐
Difficulty speaking ☐	Difficulty speaking ☐	Food ☐
Other:	Other:	Which Foods?
		Other Triggers:

Does your child need assistance taking their medication? **Yes / No (Please circle)**

Any other information that will assist with the asthma management of the student?
e.g. peak flow action plan, night time asthma, recent attacks (attach additional information if necessary)

_____

_____

What is the usual medicine regime followed?

Medication Requirements: (including preventers, symptom controllers, medication before exercise)		
Name of Medication	**Method** **(e.g. puffer & spacer, turbuhaler)**	**Details**

Asthma First Aid Plan

Please tick the preferred First Aid Plan

☐ Victorian Schools Asthma Policy for Emergency Treatment of an Asthma Attack:

Section 4.5.7.8 of The Department of Education
Schools of the Future Reference Guide

1. Sit the student down and remain calm to reassure the student.
2. Without delay give 4 puffs of a Reliever Inhaler (Ventolin, Respolin or Bricanyl), using a spacer. Spacer technique equals 1 puff, then take 4 breaths from spacer, repeat until 4 puffs have been given.
3. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per step two.
4. If there is no improvement, call an ambulance (000) immediately and state that "a student is having an asthma attack".
5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

OR

☐ Student's Emergency Treatment (if different from above):

- In the event of an asthma attack at school, I agree to my child receiving the treatment described above.
- I authorise school staff to assist my child with taking asthma medication should they require help.
- I will notify you in writing if there are any changes to these instructions.
- Please notify me if my child regularly has asthma symptoms at school.
- Please notify me if my child has received asthma first aid.
- I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent / Guardian Signature: _____ **Date:** ____/____/____

Doctor's Signature: _____

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly Schools Program and asthma management please contact: Asthma Victoria on (03) 9326 7088 or Toll Free 1800 645 130 or visit our web site www.asthma.org.au.