

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 child's 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

<b>Dentist</b>	_____	<b>Phone:</b> _____
<b>Doctor</b>	_____	<b>Phone:</b> _____
<b>General Practice</b>	_____	<b>Phone:</b> _____
<b>Specialist</b>	_____	<b>Phone:</b> _____

## 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)

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**I hereby acknowledge that the information provided is accurate.**

Signature of Parent / Guardian (Please circle) \_\_\_\_\_

Please print your name \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Appendix A: Medical Conditions

<b>ADD/ADHD</b>	Yes / No (Please circle)	Medication: _____
<b>Allergy</b>	Yes / No (Please circle)	Food Allergy: _____ Drug/Ointment Allergy: _____ Other: _____ Additional Details: _____
<b>Anaphylaxis</b>	Yes / No (Please circle)	EpiPen Expiry Date: _____ Current Action Plan supplied: _____ Antihistamine Dosage: _____ Additional Details: _____
<b>Asthma</b>	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?: _____
<b>Behaviour/Learning Condition</b>	Yes / No (Please circle)	Additional details: _____
<b>Cardiac/Heart Conditions</b>	Yes / No (Please circle)	Additional details: _____
<b>Diabetes</b>	Yes / No (Please circle)	Supplied Management Plan?: _____
<b>Eczema</b>	Yes / No (Please circle)	Additional details: _____
<b>Epilepsy/Seizures</b>	Yes / No (Please circle)	Triggers: _____ Supplied Management Plan?: _____ Additional Details: _____

<b>Food Intolerance</b>	Yes / No (Please circle)	Additional details: _____
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<b>Hayfever</b>	Yes / No (Please circle)	Additional details: _____
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<b>Headache/Migraine</b>	Yes / No (Please circle)	Additional details: _____
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<b>Hearing</b>	Yes / No (Please circle)	Additional details: _____
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<b>Other Condition</b>	Yes / No (Please circle)	Additional details: _____
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<b>Period Pain</b>	Yes / No (Please circle)	Additional details: _____
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<b>Recent Injury/Illness</b>	Yes / No (Please circle)	Additional details: _____
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<b>Recent Operation</b>	Yes / No (Please circle)	Additional details: _____
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<b>Travel Sickness</b>	Yes / No (Please circle)	Additional details: _____
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<b>Vision</b>	Yes / No (Please circle)	Colour Blind: _____
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**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 <input type="checkbox"/>	Wheezing <input type="checkbox"/>	Exercise <input type="checkbox"/>
Tightness in chest <input type="checkbox"/>	Tightness in chest <input type="checkbox"/>	Colds/Viruses <input type="checkbox"/>
Coughing <input type="checkbox"/>	Coughing <input type="checkbox"/>	Pollens <input type="checkbox"/>
Difficulty breathing <input type="checkbox"/>	Difficulty breathing <input type="checkbox"/>	Dust <input type="checkbox"/>
Difficulty speaking <input type="checkbox"/>	Difficulty speaking <input type="checkbox"/>	Food <input type="checkbox"/>
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](http://www.asthma.org.au).