CHERTSEY PRIMARY SCHOOL

Willow Road, Springfield NSW 2250 • Phone (02) 4325 3963 (02) 4323 1443 • Fax (02) 4323 6891

Medical information form – School Athletics Carnival

The information provided on (...../...../**2014**) by [***Name***.....] is being obtained for the purpose of ascertaining relevant medical information, requirements and other health care related needs about [***student name***.....] who is currently enrolled at the school and who may participate in school excursions, sporting activities or other educational or school activities conducted by or in conjunction with Chertsey Primary School.

It will be used by officers of the NSW Department of Education and Training to assist planning, to support students, and to minimise risks when conducting school excursions, sporting or other school activities.

Other persons or agencies that may be provided with this information include, but are not limited to, volunteers and members of external organisations who join with the school or are otherwise involved in the planning or delivery of the excursion, sporting or other school activity; and persons that may be called upon to provide health care treatment or other assistance during or as a consequence of such excursions or activities.

Provision of this information is not required by law. However, a failure to provide the information may mean that your child can not participate in a particular excursion or school activity. In such circumstances the school will make available a sound alternative educational experience.

Provision of this information will significantly assist the school in planning a safer educational activity. It will be stored securely. If you have any concerns about provision of this information, please contact the school principal to discuss further.

You may correct any personal information provided at any time by contacting the school office.

Student name: ..... ***Class:*** .....

**Medicare number* (optional)* .....

Private Health Fund cover? *YES / NO* *(please circle)*

Health Fund: ..... *Membership Number* .....

Ambulance Cover? *YES / NO* *(please circle)*

Health Fund: ..... *Membership Number* .....

Parent or caregiver contact details

Name: .....

Address: .....

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Home phone: ..... *Work*: ..... *Mobile*: .....

Doctor contact details

Name: .....

Address: .....

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Doctor's telephone: *1.* ..... *2.* .....

Emergency contact(s) details (nominated by the parent or caregiver as alternate contact)

1. Name: ..... *Phone*: .....

2. Name: ..... *Phone*: .....

Medical Information

Does the participant suffer from any of the following?

☐ Any allergic condition ☐ Skin condition ☐ Diabetes

☐ Epilepsy, fits or blackouts ☐ A disability or chronic illness ☐ Asthma (include asthma plan)

☐ Attention Deficit Disorder (ADD/ADHD) ☐ Sleep walking ☐ A current illness eg. flu

☐ Bed wetting ☐ Behavioural problems ☐ Other _____

If yes to one or more, please give details and a suggested management guide (attach sheet if required)

List existing medical conditions or illnesses (which are not listed above). Outline the treatment for each.

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Outline special dietary needs including possible reaction to inappropriate diet

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Current Medication

	Time and Dosage – Please specify exact time of medication									
	Breakfast		Lunch		Dinner		Before bed		Other	
Name	Time	Dose	Time	Dose	Time	Dose	Time	Dose	Time	Dose
Eg. Bricanyl	8am	2 puffs	12.30pm	2 puffs	6pm	2 puffs	8 pm	2 puffs		

Notes:

1. Scheduled medication must be provided in the original container (as required by legislation)
2. All medications will be collected by staff, unless notified in writing to the contrary.
3. Staff will register the taking of all medication and will supervise children while they self administer medication.

Medication(s) to be administered during the excursion. Include name of medication, instructions for administration, time of administration, and any possible reactions

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Signature: ..... *Date*: .....

Please return this form by: **MONDAY 23rd JUNE 2014** *(WEEK 9)*