



St Matthew's Collegiate School CONFIDENTIAL MEDICAL INFORMATION FORM

INTERNATIONAL STUDENT DETAILS

Commencing Year: _____

Boarder

SURNAME: _____

FIRST NAME: _____

Date of Birth: _____

Religion: _____

Home Address: _____

Postal Code: _____

Year into which student was enrolled (please circle): 7 8 9 10 11 12 13

Please inform the International Director of any changes to above information

IMMUNISATION RECORD

Year of last Tetanus or ADT booster: _____ Year of last Hepatitis B vaccination: _____

Year of last Polio booster: _____ Other: _____

Year of last Measles/Mumps/Rubella: _____

CHILDHOOD DISEASES (tick if your child has had any of the following)

- Chicken Pox Glandular Fever Mumps Measles German Measles
 Whooping cough Croup Other (specify) _____

ASTHMA HISTORY

Asthma History: Does your child suffer from Asthma? Yes No

Has your child been to hospital due to asthma in the past 2 years? Yes No

Medication taken for asthma: _____

MINOR ALLERGY RELIEF

For the relief of minor allergies the following medication may be given.

Please sign to authorise us to give this to your daughter if required.

Claratyne Polaramine, (antihistamine) _____

OPERATIONS AND OTHER INJURIES

Please provide details of any operations or other injuries your child has experienced, eg date, treating doctor or hospital etc.

MEDICAL HISTORY

- Diabetes
- Epilepsy
- Attention deficit disorder
- Other (Specify): _____

OTHER HEALTH ISSUES THE SCHOOL SHOULD BE AWARE OF

eg Hepatitis B carrier, bed wetting, psychological problems, special needs/disability

CURRENT TREATMENT(S) OF WHICH THE SCHOOL SHOULD BE AWARE

PHARMACY MEDICATIONS

The following pharmacy medications are held in the Matrons' Office for the relief of minor pain, coughs, colds and fever. Please sign beside each medication that is authorised to be given to your child if required.

- Gees Linctus _____
- Panadol _____
- Disprin _____

PRESCRIPTION MEDICATIONS

List prescription medications, their dose and frequency, that your child is currently taking.

MEDICAL CONSENT FORM

I/We _____(print names)
being the parent(s) / guardian(s) of _____(student's name)
provide the information as requested in this form and also consent to the administration of medications specified in the Medical History form and any others as notified by me/us, in writing as required.

I/We undertake to inform you in writing of any changes to the information in this form as and when necessary.

Signed: _____ Date: _____
Parent/Guardian
Telephone Numbers: Home: _____ Work: _____ Mobile: _____

Signed: _____ Date: _____
Parent/Guardian
Telephone Numbers: Home: _____ Work: _____ Mobile: _____

In the event we are unable to contact you (the parents or guardians), please nominate a person to contact in an emergency.

NAME: _____

Telephone Numbers: Home _____ Work _____ Mobile _____