St Matthew's Collegiate School
CONFIDENTIAL MEDICAL INFORMATION FORM

STUDENT DETAILS

Commencing Year:___________ ❑ Day Student or ❑ 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

Family Doctor:___________________________ Phone No:_______________

Family Dentist:__________________________ Phone No:_______________

Please inform the School Office 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

Has your child been treated with oral cortisone in the past 12 months? ❑ Yes ❑ No

- If you answered "Yes" to any of the above provide additional relevant information, e.g. dates, dosage etc.

____

____

____

Does your child have an asthma action plan? (if yes please enclose) ❑ Yes ❑ No

Their current reliever is:____________________ Their current preventer is:________________

Other 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 __________________________

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

____

____

____

"OVER THE COUNTER" MEDICATIONS

The following "over the counter" 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.

Panadol _________________________

Ibuprofen _________________________

List "over the counter" medication other than above list that your child may need and for what conditions. These will not be provided by the school.

____

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______________