ENROLMENT OFFICER USE ONLY	HEALTH CENTRE USE ONLY
Student ID _____	Date Entered _____
Date Starting _____	Entered by _____

KingsWay School
MEDICAL INFORMATION

Student's Name: (First)……..……(Surname)……
Date of Birth:…….
Student's Class Level…… …….

THE INFORMATION SUPPLIED ON THIS FORM IS SUBJECT TO THE PROVISIONS OF THE PRIVACY ACT 1993. INFORMATION IS CONFIDENTIAL TO THE STAFF OF KINGSWAY SCHOOL ONLY. IF ANY DETAILS SUPPLIED ON THIS FORM CHANGE AT ANY TIME DURING THE YEAR IT IS ESSENTIAL THAT YOU INFORM THE SCHOOL OFFICE.

*******PLEASE ADVISE THE SCHOOL IMMEDIATELY OF ANY CHANGES TO CONTACT DETAILS OR MEDICAL CONDITIONS*******

1. Does your son/daughter suffer from any of the following: (Please tick)

Anaphylactic shock	Yes		No	
Allergies	Yes		No	
Blackouts	Yes		No	
Migraine	Yes		No	
Heart Condition	Yes		No	
Travel Sickness	Yes		No	
Dizzy Spells/seizures/epilepsy	Yes		No	
Fits of any type	Yes		No	
Diabetes	Yes		No	
Asthma(explain severity)	Yes		No	
Back problems	Yes		No	
Arthritis	Yes		No	
ADD or ADHD	Yes		No	

Other: *(specify below)*

If you indicated YES for any of the above conditions: please supply any relevant details that may be necessary for emergency care, ongoing care during school hours or on school trips. Indicate any medication that is needed at school (these must be provided by you and will be kept in the school medical care room).

Condition:
Details:
Condition:
Details:
Condition:
Details:
Condition:
Details:

2. Does your son/daughter have: (*please tick*)

Eyesight Problems	Yes		No	
Hearing Difficulties	Yes		No	

Specify:

3. Does your son/daughter have any allergies: *(please tick)*

Food	Yes		No		Bee / Wasp Stings	Yes		No	
Drugs	Yes		No		Penicillin	Yes		No	
Aspirin	Yes		No		Other	Yes		No	

Specify:

4. My son/daughter has had tetanus immunization in the last five years: *(Please tick)*

   Yes No

5. In the event of your son/daughter becoming unwell at school, **permission is sought** for staff to administer any medication. **No medication can be given without permission.**

   Please indicate whether your child is allowed to be given the following medication:

Paracetamol (weight appropriate dose) **Middle and Senior School Only**	Yes		No	
Topical creams (for treating bites, burns, bruises, aches and pains)	Yes		No	

Any other medications your child should receive during school hours must be brought to school in original container with pharmacy label attached. Medication must be kept in the medical room. Students (Years 1-6) must not carry medications in their school bags or keep them in their desks. They must be taken to the school office.

6. Children who become unwell during school hours are sent to the Health Centre. If the child does not improve within an hour, parents are contacted to collect the child. Please supply the name of a friend or relative who can collect your son/daughter in the event of staff being unable to contact parents or caregivers.

Mother	**(home)**	**(work)**	**(Mob)**
Father	**(home)**	**(work)**	**(Mob)**

Name of alternate caregiver:
Relationship:
Address:
Phone Number: (home) (Mob)

Please ensure that the person you have named above is aware they have been listed as a contact. ***IN THE EVENT WE CANNOT CONTACT YOU IN AN EMERGENCY A STAFF MEMBER WILL TAKE YOUR CHILD TO THE NEAREST MEDICAL CENTRE AND ACT AS 'LOCO PARENTIS' OR AN AMBULANCE WILL BE CALLED.***

7. The information supplied is to assist staff in risk management planning. Please supply any additional information that you consider important for staff to know in the treatment and care of your child at KingsWay School.

Name of Doctor:…….Phone…….…….

Name of Dentist / Dental Nurse…… ……..…. Phone……..

Signed:…….*Parent/Caregiver*……..

Date:……