



# RED BEND CATHOLIC COLLEGE FORBES

## MEDICAL INFORMATION FORM

Student's Family Name: \_\_\_\_\_ Given Names: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ Religion \_\_\_\_\_ Address: \_\_\_\_\_  
School Year \_\_\_\_\_ in 20\_\_\_\_\_ Post Code \_\_\_\_\_

Mother's Full Name: \_\_\_\_\_ Phone (Home): ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ Phone (Work): ( ) \_\_\_\_\_  
\_\_\_\_\_ Post Code: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Fax: \_\_\_\_\_  
e-mail: \_\_\_\_\_

Father's Full Name: \_\_\_\_\_ Phone (Home): ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ Phone (Work): ( ) \_\_\_\_\_  
\_\_\_\_\_ Post Code: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Fax: \_\_\_\_\_  
e-mail: \_\_\_\_\_

Other Contacts:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL CONSENT FORM

To: **THE PRINCIPAL,**

I/we: \_\_\_\_\_ (Parent/guardian – please print names)

Being the parent/guardian of \_\_\_\_\_ (please print name of student)

Consent to the administration of medications specified in Section One (over page) and any others as notified by me/us in writing as required and also provide the information as requested in Section Two of this form.

I/we authorise you in the event of injury to or illness of our son/daughter (guardian), to follow the procedure(s) set out in Section One (over page) of this consent.

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

This consent shall remain valid unless withdrawn and notified by myself/us in writing to the school.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent/guardian)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent/guardian)

**MEDICATION PROCEDURES**

- Parents are requested to inform the Health Centre of any medications being taken by students:
- All medications taken during the school day should be stored in the Health Centre unless other arrangements are made with nursing staff.
- All medications administered by the school nurse will be recorded.

**Prescription and Restricted Medications:**

- Assistance will be given by the school nurse in the administration of prescribed medication, when requested in writing by parents/guardians and as prescribed by the doctor.
- Assistance will be given by the school nurse in the administration of **Restricted** medication (such as Ritalin, Dexamphetamine) after receiving documentation from the doctor and parent.
- Instructions regarding changes to the original dosage of long term or restricted medication must be in writing from the doctor and parent/guardian.
- The school nurse may only administer or assist with the administration of any medication if the medication provided in its **original container** with label clearly displaying the **students name** and the **required dosage**.
- All medications will be stored in a locked cupboard in the Health Centre.

**BOARDING STUDENT MEDICATION**

**Non-prescription or 'Over the counter medications'**

Some of the non-prescription medications are held in the Health Centre for the relief of minor pain, coughs, colds, fever. Please **sign** beside each medication that you authorise us to administer to your son/daughter if required:

**Abdominal Discomfort**

Donna Tab \_\_\_\_\_

**Analgesia & Anti-inflammatory**

Panadol \_\_\_\_\_

Nurofen (Ibuprofen) \_\_\_\_\_

Ponstan \_\_\_\_\_

Naproxen Sodium \_\_\_\_\_

**Antihistamine**

Telfast \_\_\_\_\_

Claratyne \_\_\_\_\_

Phenergan \_\_\_\_\_

Demazin \_\_\_\_\_

**Cough & Cold Flu Tablets**

Cold Flu Tablets \_\_\_\_\_

**Cough & Cold Mixtures**

Benadryl (cough mixture) \_\_\_\_\_

Bisolvon (cough mixture) \_\_\_\_\_

Throat Gargles \_\_\_\_\_

Throat Lozengers \_\_\_\_\_

**Travel Sick Tablets**

Hyoscine Hydrobromide \_\_\_\_\_

**Anti Diarrhoea**

Loperamide Hydrochloride \_\_\_\_\_

Please list below any **other non-prescription medications** that your son/daughter may need and the name of the condition.

\_\_\_\_\_

\_\_\_\_\_

**DAY STUDENT MEDICATION**

**Non-prescription or 'Over the counter medications'**

Due to new Department of Health regulation (Pharmaceutical Branch) no medication may be given to day students unless authorised and supplied as stated above by parents. Panadol tablets, Panadol mixture and Disprin will be held in the Health Centre should it be required by your son/daughter. Any other medications will need to be supplied to the Health Centre with your son/daughters' name and instructions for use. **Please sign for Panadol if you authorise us to administer this to your son/daughter if required:**

Panadol \_\_\_\_\_

Please list below any other **non-prescription medications** that your son/daughter may need and the name of the condition being treated. If your son/daughter requires these medications reasonably often, (eg migraine; allergy) please supply a small box of the medication to the Health Centre with your son/daughter name and with instructions as to dosage and frequency.

\_\_\_\_\_

\_\_\_\_\_

**1. IMMUNISATION RECORD:**

Year of last Tetanus or ADT Booster: \_\_\_\_\_

Year of last Polio Booster: \_\_\_\_\_

Year of last Measles/Mumps/Rubella: \_\_\_\_\_

Year of last Hepatitis B vaccination: \_\_\_\_\_

Other: \_\_\_\_\_

**2. CHILDHOOD DISEASES:**

Chicken Pox       Glandular Fever       Mumps       Measles

Whooping Cough       Rubella(German Measles)       Rheumatic Fever       Croup

Other (Please specify) \_\_\_\_\_

**3. ASTHMA HISTORY:**

Asthma History: Does your son/daughter suffer from Asthma?      Yes       No       **If yes:**

Has your son/daughter been to hospital due to asthma in the past 2 years?      Yes       No

Has your son/daughter been treated with oral cortisone in the past 12 months?      Yes       No

Does your son/daughter have an asthma action plan? (If yes please enclose)      Yes       No

His/Her current **Reliever** is: \_\_\_\_\_      His/Her current **Preventer** is: \_\_\_\_\_

Other medication taken for asthma?

**4. MEDICAL HISTORY:**

**Diabetes:** Yes       No       **Epilepsy:** Yes       No       **Attention Deficit Disorder:** Yes       No

Other health issues the school should be aware of:

eg. Special Needs or Disability; Learning Difficulties/Problems; Fainting; Hepatitis B Carrier; Incontinence;

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**5. ANY COUNSELLING OR PSYCHOLOGICAL ISSUES OF WHICH THE SCHOOL SHOULD BE AWARE:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**6. PRESCRIPTION MEDICATIONS:**

Please list prescription medications, the dosage and frequency that your son/daughter is currently taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

**7. ALLERGIES and TREATMENTS REQUIRED:**

**Medications:** \_\_\_\_\_

**Food:** \_\_\_\_\_

**Insects:** \_\_\_\_\_

**Other:** \_\_\_\_\_

8. OPERATIONS AND OTHER INJURIES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. CURRENT TREATMENTS THAT THE SCHOOL SHOULD BE AWARE OF:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. DOES YOUR SON/DAUGHTER HAVE HEARING OR SIGHT DIFICULTIES: eg glasses

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADDITIONAL INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL DETAILS**

Medicare Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ month \_\_\_\_\_ year Position on Card: \_\_\_\_\_

Private Health Fund: \_\_\_\_\_ Member Number: \_\_\_\_\_

Pension Type: \_\_\_\_\_ Health Care Card No.: \_\_\_\_\_  
(Austudy & Prescription Quota please inform yearly)

Family Doctor: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_

Orthodontist: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_

Emergency and/or Guardian Name, Address, Phone:  
\_\_\_\_\_  
\_\_\_\_\_

Please state briefly any HEALTH ISSUES, MEDICAL ALERTS or SPECIAL NEEDS of which staff need to be aware.

\_\_\_\_\_  
\_\_\_\_\_

Information on this page will be sent to Principal, Director of Boarding, Counsellor, Relevant teaching staff.

Please sign here if you **DO NOT** want this information sent to the above staff. **SIGN:** \_\_\_\_\_