



Student Medical Information

Student Name		Date of Birth	
Community Health Centre			
Family Doctor's Name		Phone Number	
Medicare Card Number	Copy required for student file	Ref No.	Exp.
Health Care Card No.	Centrelink Reference Number		
Blood Group (if known)			

Immunisations

Has your child been fully immunised? <i>Please attach a copy of immunisation register from your Doctor or Medical Centre</i>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Illness

Is your child under medical treatment at present?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Give Details:

Is your child taking any medications at present?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Give Details:

Does your child suffer from any of the following?

Asthma / Bronchitis / breathing problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Headaches / migraines	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Allergies to any substance, medication, foods, bites or stings	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hearing problems / wears hearing aids / ear infections	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Eye problems / wears glasses / contact lens	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Tooth Decay or other dental problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Rheumatic Heart Disease / Heart Murmur / Chest Pains	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hepatitis A, B or C	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
HIV	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes Type 1 / Type 2	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Epilepsy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
TB sickness	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Kidney problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Attention Deficit Hyperactivity Disorder ADHD	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Anxiety / Depression	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Anemia, leukemia or any other blood diseases	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If you answered yes to any of the questions can you please provide more information

Give Details:



Consent for Emergency Treatment

I give permission to the Manager or a Senior Supervisor AFLCY House to initiate immediate First Aid or Hospital care for my child and to sign on my behalf for any treatment in the event of a medical emergency if I cannot be contacted.

Parent/Guardian Signature	Date
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Consent for Release of Medical Information

Your local Health Centre may have medical information about your child which could help the staff at AFLCY House to care for your child's health better. If necessary, some of this information may also be provided to the school which your child will attend. All information is kept strictly confidential.

I, _____ (parent/guardian full name)

Give permission for the Community Health Care Centre at _____ to give the AFLCY House medical staff information from my child's medical records if necessary. I understand that some of this information may also be given to the school which my child attends if necessary.

Parent/Guardian Signature	Date
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Parental Consent

Please tick, sign and date all sections of this form

Student Name	Date of Birth
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Medical Consent

Do you give permission for?

AFLCY House staff to administer Panadol to your child (if necessary)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
AFLCY House staff to administer prescribed medication as instructed by a doctor	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Your child to participate in School and Medical Health Programs (including health assessment by a doctor, immunisation, health referrals and well-being programs)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Your child to participate in Wellbeing and Health information sessions	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Head lice checks and treatment for your child	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Your child to receive Dental assessment and treatment if required	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Your child to receive treatment for vision / hearing / speech if necessary	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Your child to undergo counselling with a professional Counsellor if necessary	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Your child to receive physiotherapy if necessary	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Your child to receive treatment in regards to pharmacy medicine i.e. Vicks Chest Rub, Antifungal Creams, Antiseptic Creams (Savlon, Dettol, Betadine, other), Throat Lozenges, Ice gel, Heat Rub, Boil Treatment, Scabies Treatment, Eye Drops/ Ointment, Ear Drops, Rash/ Bite Treatment, Insect Repellant, Sun Screen	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Please list items you DO NOT consent to:	No	<input type="checkbox"/>
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Immunisation Record attached?	Yes <input type="checkbox"/>	Health Record from Doctor attached?	Yes <input type="checkbox"/>
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I agree to pay for any medical / dental / physiotherapy / counselling costs not covered by Medicare. You will receive a phone call to discuss any treatment that requires further consent and payment.

Parent/Guardian Signature	Date
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