AFL Cape York House

Student Medical Information and Consent Form

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.	
Centrelink Reference No.					
Blood Group (if known)					

Immunisations				
Has your child been fully immunised? *Please attach a copy of immunisation register from your Doctor or Medical Centre*	Yes	☐	No	☐

Illness				
Is your child under medical treatment at present or taking any medications?	Yes	☐	No	☐
Give Details:				
Does your child suffer from any of the following?				
Asthma / bronchitis / breathing problems	Yes	☐	No	☐
Headaches / migraines	Yes	☐	No	☐
Allergies to any substance, medication, foods, bites or stings	Yes	☐	No	☐
Hearing problems / wears hearing aids / ear infections	Yes	☐	No	☐
Eye problems / wears glasses / contact lens	Yes	☐	No	☐
Tooth Decay or other dental problems	Yes	☐	No	☐
Rheumatic Heart Disease / Heart Murmur / Chest Pains	Yes	☐	No	☐
Hepatitis A, B or C	Yes	☐	No	☐
HIV	Yes	☐	No	☐
Diabetes Type 1 / Type 2	Yes	☐	No	☐
Epilepsy	Yes	☐	No	☐
TB sickness	Yes	☐	No	☐
Kidney problems	Yes	☐	No	☐
Attention Deficit Hyperactivity Disorder ADHD	Yes	☐	No	☐
Anxiety / Depression	Yes	☐	No	☐
Anemia, leukemia or any other blood diseases	Yes	☐	No	☐
If you answered YES to any of the questions, can you please provide more information:				

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/ Hospital in _____ (Community Name)

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**	

Parental Consent

Please tick, sign and date all sections of this form

Student Name		**Date of Birth**	

Medical Consent

Do you give permission for?				
AFLCY House staff to administer Panadol to your child (if necessary)	Yes	☐	No	☐
AFLCY House staff to administer prescribed medication as instructed by a doctor	Yes	☐	No	☐
Your child to participate in School and Medical Health Programs (including health assessment by a doctor, immunisation, health referrals and well-being programs)	Yes	☐	No	☐
Your child to participate in Wellbeing and Health information sessions	Yes	☐	No	☐
Head lice checks and treatment for your child	Yes	☐	No	☐
Your child to receive dental assessment and treatment if required	Yes	☐	No	☐
Your child to receive treatment for vision / hearing / speech if necessary	Yes	☐	No	☐
Your child to undergo counselling with a professional Counsellor if necessary	Yes	☐	No	☐
Your child to receive Allied Health Services i.e., physiotherapy if necessary	Yes	☐	No	☐
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	☐	No	☐

If you answered NO to any of the questions, can you please provide more information:

Immunisation Record attached?	Yes ☐	**Health Record from Doctor attached?**	Yes ☐

Consent for Emergency Treatment

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**	