



# Donvale Christian College

## Student Medical Information Form 2010

**OFFICE USE ONLY:**

2010 Year: \_\_\_\_\_

2010 HG: \_\_\_\_\_

2010 Class: \_\_\_\_\_

**IMPORTANT INFORMATION:** *Students must have a completed form returned to College before they are able to participate in sporting and off-campus activities. For your child's safety it is essential to complete and return the form as requested and to notify the College promptly of any changes.*

**STUDENT DETAILS:**

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

**PARENT/GUARDIAN CONTACT DETAILS:** *Please complete FULL DETAILS for BOTH parents.*

**Father/Male Guardian:**

**Mother/Female Guardian:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile/Pager: \_\_\_\_\_

Mobile/Pager: \_\_\_\_\_

**EMERGENCY CONTACT:** *(Other than Parents)*

**This section MUST BE completed with the names of TWO contacts (other than parents) who could come to the College and authorise medical treatment or take your child home in an emergency.**

1. Name: \_\_\_\_\_

2. Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

**DOCTOR DETAILS:**

Name of Family Doctor: \_\_\_\_\_

Phone No: \_\_\_\_\_

*If your child suffers from any of the following, please indicate by ticking the appropriate box.*

Condition	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Other medical condition	<input type="checkbox"/>	<input type="checkbox"/>
Asthma ( <i>See form enclosed</i> )	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes" to any of these conditions, please provide further information in "Details of Medical Condition" box below.

If "Yes" to Asthma, complete "**Asthma Management Plan**"

**Details of Medical Condition** *(Other than Asthma):*

Name of condition & other relevant information: \_\_\_\_\_

Is your child currently on prescription medication for this condition? Yes  No

Is this condition likely to require treatment at school? Never  Occasionally  Regularly

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time taken: \_\_\_\_\_

**Any medication to be administered to students MUST BE left with the First Aid Officer or College Office.**

**PLEASE COMPLETE BOTH SIDES AND SIGN AND DATE THE FORM BEFORE RETURNING IT - THANK YOU.**

**VACCINATIONS** - *Has your child been vaccinated in accordance with the normal school vaccination program?*

Yes

No

**OTHER MEDICAL INFORMATION:**

List any other relevant medical information: \_\_\_\_\_

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

**AUTHORITY**

*I/we give permission for the following:*

- **for my child to be inspected for head lice** when deemed necessary by the College.
- **In the case of an emergency and where it is impractical to contact me/us**, I/we authorise the College to arrange for such medical or surgical treatment as may be deemed necessary. I/We indemnify the College against all costs arising from such action including ambulance charges. If the College is unable to contact me/us or the emergency names listed, I/we give permission for my/our child to be taken by ambulance to the Casualty Department of the nearest hospital.
- **sporting events** notification. In the event of accident or illness, where it is impractical to communicate with me/us, I authorise the teacher in charge to consent to my/our child receiving such medical, surgical or ambulance treatment as may be deemed necessary. I/We agree to meet any costs which may be incurred.
- I/We also understand that certain medical information held by the College about my/our child may need to be passed on to emergency services personnel to assist in their care. I/we hereby give consent for the disclosure of this information as required.

\_\_\_\_\_  
*Signature: Father/Male Guardian*

\_\_\_\_\_  
*Signature: Mother/Female Guardian*

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*PRIVACY POLICY – Please see the College website for details ([www.donvale.vic.edu.au](http://www.donvale.vic.edu.au))*