



STUDENT HEALTH FORM

STRICTLY CONFIDENTIAL

This information will enable excursion organisers to provide health care for your child.

Student's name: _____ Date of birth: _____

Room Number: _____

Parent/guardian's full name: _____

Address: _____ Postcode: _____

Telephone number: Home: _____

Work: _____

Mobile: _____

Name of family doctor: _____ Telephone number: _____

Medicare number: _____

Health conditions

Is your child subject to seizures, fainting, epilepsy, diabetes, asthma or any other condition that may affect his or her safety during the excursion?

Yes No

If "yes", please give details: _____

Is your child allergic to:

(Please tick)

Any medications

Any food

Any insect stings

Other

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Please give details:

Date of last tetanus vaccination: _____

Medication

Parents/guardians are requested to make arrangements with the teacher-in-charge for the safekeeping and handling of prescribed medications prior to the excursion.

Is your child presently taking tablets and/or other forms of prescribed medication? Yes No

Does your child self administer the medication? Yes No

If "yes", state name of medication, dosage and frequency of use:

Does your child have a current Health Care Authorisation Plan at school? Yes No

Other information

Please provide any other information about your child which will enable the organisers of the excursion to provide better care for your child.

Signature of Parent/Guardian: _____

Date: _____