Medical Form

STUDENT DETAILS			
SURNAME:		GIVEN NAME/S:	
DATE OF BIRTH:	/ /		

EMERGENCY CONTACTS					
NAME:				RELATIONSHIP:	
PHONE NUMBERS:	Home		Work		Mobile
NAME:				RELATIONSHIP:	
PHONE NUMBERS:	Home		Work		Mobile

HEALTH INSURANCE DETAILS			
INSURANCE COMPANY:			
TYPE OF COVER:		POLICY NUMBER:	
MEDICARE NUMBER:			
EXPIRY DATE:		POSITION ON CARD:	

MEDICAL HISTORY			
ALLERGIES AND REACTIONS:	*Please list details and dates*		
SURGICAL AND MEDICAL PROCEDURES:	*Please list details and dates*		
Including fractures/broken bones, removal of moles and warts etc, operations, major illnesses and hospitalisation.			
IMMUNISATIONS:	*Note – It is not mandatory for students to be immunised however it is recommended*		
Tetanus/Diphtheria			
Measles/Mumps/Rubella	1st	2nd	
Hepatitis B	1st	2nd	3rd
Q Fever			
Chicken Pox	1st	2nd	
Meningococcal			
Other Immunisations:			

MEDICAL CONDITIONS:	*If yes, please provide details below*										
	Y	N		Y	N		Y	N		Y	N
Sight			Hearing			Heart			Glandular Fever		
Lungs			Measles			Mumps			Ross River Fever		
Diabetes			Epilepsy			Hay Fever			Dengue Fever		
Kidneys			Asthma			Sinus			Chicken Pox		
Details:											

CURRENT TREATMENT

Are you currently receiving or recently received ongoing care by any of the following, other than for minor ailments?		
Doctor	Yes ☐	No ☐
Physiotherapist	Yes ☐	No ☐
Chiropractor	Yes ☐	No ☐
Psychiatrist	Yes ☐	No ☐
Psychologist or Counsellor	Yes ☐	No ☐
Do you currently use any of the following?		
Prescription Medication	Yes ☐	No ☐
Non-prescription Medication	Yes ☐	No ☐
Cigarettes	Yes ☐	No ☐
Alcohol	Yes ☐	No ☐
If you have ticked YES to any of the above please provide details, including type, dose and frequency.		

For those students who are active sports people and suffer from muscular related injuries, please be advised that DSHS Bunya Campus does not provide strapping, sporting bands or supports e.g. knee guards etc.

MEDICAL DECLARATION

Do you have any psychological and/or physical condition/s which could influence the health and safety of yourself or those around you in classroom, farm work, recreational, dining or residential situations?

Yes ☐ No ☐

I hereby advise that the information contained within this document is true and correct. I understand that failure to disclose a condition is a serious threat to workplace health and safety and may endanger the lives of students and staff.

Parent/Guardian	*Date*
Student	*Date*

MEDICAL CONSENT		
GENERAL TREATMENT:	I authorise DSHS Bunya Campus First Aid Officers to assess myself/the student and where necessary organise follow up care. This will include making medical appointments or other appointments as necessary. I understand that for students under 16 years of age, where possible, consent will be sought prior to the event.	
	Parent/Guardian	*Date*
	Student	*Date*
MEDICATIONS:	I authorise DSHS Bunya Campus staff, in accordance with packaging directions, to administer prescribed medications, as determined by a treating medical practitioner. I authorise DSHS Bunya Campus staff, in accordance with packaging directions, to administer "over – the- counter" medications as determined by a Pharmacist without a Doctor's prescription.	
	Parent/Guardian	*Date*
	Student	*Date*
RELEASE OF INFORMATION:	I authorise DSHS Bunya Campus staff to discuss my injury/illness/results with the treating medical professional (e.g. doctor, physiotherapist and chiropractor). I understand this consent is required to assist with the student's work/training schedule. All information will be treated as confidential and will remain with DSHS Bunya Campus.	
	Parent/Guardian	*Date*
	Student	*Date*
EMERGENCY TREATMENT:	I authorise DSHS Bunya Campus to act/sign on my behalf in authorising anaesthetics and any other medical treatment, should this be necessary in the case of emergencies.	
	Parent/Guardian	*Date*
	Student	*Date*