St Thomas Aquinas
West Belconnen

2020 MEDICAL INFORMATION and CONSENT FORM

This form is to be completed by parents/guardians in consultation with their child's doctor, where necessary. Parents/Guardians should inform the school immediately if there are any changes to the plan. Please print your answers clearly in the blank spaces where indicated.

Please return to school by the end of February 2020.

This form is intended to be used to assist the school in the case of any medical treatment required or medical emergency involving a student at school. The School collects the information contained in this form to provide or arrange first aid and other medical treatments for students. The information collected will be held at school and will be made available to staff of the school and to medical or paramedical staff in the case of an accident or emergency. The information contained in the form is personal information and it will be stored, used and disclosed in accordance with the requirements of the Privacy Act 1998 (Cwth). Parents/Guardians note that in the absence of an Emergency Treatment Plan only standard First Aid will be administered.

STUDENT DETAILS

Student Name:		**Sex:** ☐ **Female** ☐ **Male**
Date of Birth:	**School Year:**	**Class:**

MEDICAL DETAILS

Name of Student's Doctor:	**Practice Name:**	**Contact Number/s:**
Medicare No:	**Private Health Fund Details:**	**Health Fund Membership No:**
Ambulance Fund:		*NOTE: Parents are responsible for ambulance costs.*

MEDICAL CONDITIONS AND INFORMATION

Please tick if your child suffers any of the following:

☐Allergies	☐Blood Pressure	☐Epilepsy	☐Hay Fever	☐Nose Bleeds
☐Anaphylaxis	☐Diabetes	☐Fainting	☐Headaches	☐Reaction to Drugs
☐Asthma	☐Eczema	☐Fits or Blackouts	☐Heart Condition	☐Sight/Hearing Issues

If you have ticked any of the boxes above an Emergency Treatment Plan must be provided.
*. **NB. Without an Emergency Treatment Plan the school can only provide first aid treatment**.*

Is the student presently taking any medication? ☐ **Yes** ☐ **No** NOTE: Parents must give written permission and directions for the administration of <u>any</u> medication taken during school hours or after hours school activities. Relevant forms are available from the front office and our website.	**Date of last tetanus injection:** ____ / ____ / _____

Are you aware of any physical or psychological limitations of your child? ☐ **Yes** ☐ **No**
If yes, please provide details below or attach further information.

Is there any other information which you believe may help us to provide the best possible care?

☐ **Yes** ☐ **No** **I**f yes, please provide details below or attach further information.

In an emergency, please follow the plan that has been ticked below ☑
If insufficient space, please attach additional information.

☐ **1: GENERAL MEDICAL INFORMATION**

OR

☐ **2: EMERGENCY TREATMENT PLAN PROVIDED BY DOCTOR** *(attached)*

I verify that I have read this Medical Treatment Plan and agree with its implementation

Signed by Doctor:	**Print Doctor's Name:**	**Date:**

CONSENT TO MEDICAL ATTENTION

I/We give the following permissions:

1. *In the case of my child requiring medical treatment, or in the case of a medical emergency, I consent to the school providing first aid or treatment as outlined in an Emergency Treatment Plan.*
2. *I further authorise the school, where it is impracticable to communicate with me, to arrange for them to receive such medical or surgical treatment as may be deemed necessary.*
3. *I also undertake to pay any costs which may be incurred for the medical treatment, ambulance transport and drugs.*
4. *Consent for my child to be identified by a Student Medical Alert poster, including a photograph of my child and personal information, which is to be displayed in the school's first aid room, staff room, child's classroom and other locations as considered necessary.*
5. *As a Parent/Guardian I will notify you in writing if there are any changes to these instructions.*

Signed: *(Parent/Guardian)*	**Print Name:**	**Date:**
Signed: *(Parent/Guardian)*	**Print Name:**	**Date:**