MEDICAL HISTORY FORM

To the Parents or Guardian:

Please provide details of your child's health history, to facilitate the school personnel to understand more of your child's health needs. All information provided is treated CONFIDENTIAL. Form must be completed and signed by parents at registration before the student starts school.

STUDENT DETAILS			
Student's Name Please underline surname):			
Year Level:	Gender: ☐ M ☐ F	Birth Date:	Age:

STUDENT'S HEALTH HISTORY					
Does your child have a history of any health concerns or medical conditions?					
Neurological (Eg. Seizures, Headaches, Syncope)	Yes	No	**Endocrinology/Hormonal** (Eg. Diabetes, Thyroid)	Yes	No
Heart Problems (Eg. Rhythm & Sounds)	Yes	No	**Mouth** (Eg. Teeth, Gums, Braces)	Yes	No
Breathing or Lungs (Eg. Asthma)	Yes	No	**Nose** (Eg. Congestion, Nose bleeds)	Yes	No
Muscles, Joints Bones	Yes	No	**Ears** (Eg. Infections, Grommet, Hearing)	Yes	No
Stomach, Digestion	Yes	No	**Blood Disorder** (Eg. Anaemia, G6PD, Haemophilia)	Yes	No
Skin problems (Eg. Eczema, Rashes, Scars, Psoriasis)	Ys	No	**Gynecological**	Yes	No
Kidney, Bladder	Yes	No	**Psychological Development** (Eg. Depression, Anxiety)	Yes	No
Attention Deficit Disorder/ Hyperactivity	Yes	No	**Nutritional Status** (Eg. Over/Underweight)	Yes	No
Vision/ Eyes	Yes	No	**Hospitalization/surgeries**	Yes	No
Allergies (Eg. Food, Medicine, Environment)	Yes	No	**Regularly prescribe medication**	Yes	No

Please provide details any conditions mark YES for the above:
(In the case of Asthma, severe Allergies, Diabetes, Epilepsy please discuss a Care Plan with the school.)

1.
2.____
3.____

DIETARY REQUIREMENTS						
☐ No Nuts	☐ No Seafood	☐ No Dairy Products	☐ No Cheese	☐ No Eggs	☐ Gluten Free	☐ Others (Please specify)

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PREFERENCES			
☐Halal	☐No Beef	☐Vegetarian	Others (Please specify)

Permission to give Medications: eg. Panadol, Throat Lozenges, Anti-histamines (Whilst at school, all medications, whether prescriptions or over the counter, must be dispensed from the nurse's office. With the exception of Asthma inhaler nd Epipens, students are not allowed to carry medications with them at school)	☐Yes ☐ No
Please tick if your child wears any of the following: ☐Spectacles/Contact Lens ☐Hearing Aid ☐ Support Devices	

IMMUNISATION RECORD
Please attach a photocopy of your your child's immunisation records to this application form

PARENT/GUARDIAN DECLARATION	
I declare that all the information provided above is true, to the best of my knowledge. In the event of an emergency, where a child required immediate treatment, attempts will be made to contact parents. However, the school retains the right to take immediate action in the best interest of the child. Any medical costs incurred are the responsibility of the parents or guardians.	
Signature of parents/guardians:	Date:
Name in BLOCK CAPITALS: ______________________________	