EDENS LANDING STATE SCHOOL
Excellence in Learning

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EDENS LANDING STATE SCHOOL - STUDENT MEDICAL RECORD FORM

1.

Student's name: .....**Date of Birth:** .....

Excursion/camp: .....**Date of camp:** .....

2. **MEDICAL CONDITION.** Please indicate below any known medical conditions relevant to the above named student. In those instances where there is a "YES" response, please describe the nature of the problem or provide a letter from your doctor.

Medical Condition	***Circle***	**Details**
Recent Illness/Injuries/Operations	YES/NO	
Allergies	YES/NO	
Drug Reactions (eg: penicillin allergy)	YES/NO	
Phobias	YES/NO	
Diabetes	YES/NO	
Travel Sickness	YES/NO	
Asthma	YES/NO	
Blood Pressure	YES/NO	
Epilepsy	YES/NO	
Heart Problems	YES/NO	
Respiratory problems (Other than Asthma)	YES/NO	
Other		
Date of last Tetanus Injection		
Medicare Number		
Health Fund Name and No:		

3. **MEDICAL PRACTITIONER**

Name of Family Doctor	
Address	
Telephone Number	( )

4.

CURRENT PRESCRIBED MEDICATIONS

The medication/s listed below has/have been prescribed for my son/daughter by a registered medical practitioner and will be required to be administered while my child is involved in the excursion/camp indicated in Section 1.

I hereby request the teacher accompanying the excursion, who has been so authorised by the Principal, to administer the medication/s in accordance with the instructions written on the medication container/s by the pharmacist in accordance with the medical practitioner's instructions. I understand that all unused medication/s will be returned to me.

Signature of Parent/Caregiver:_____

Print Name: _____ Date / /

NAME OF MEDICATION (including mg/mls)	DOSAGE	TIMES FOR ADMINISTRATION

5. **DISCLAIMER**

I hereby authorise the medical practitioner identified in Section 3 to provide to hospital authorities or other qualified medical practitioner(s) additional information concerning any of the medical conditions identified in Section 2 should such need arise.

Signature of Parent/Caregiver:_____

Print Name: _____ Date / /

6. **AUTHORITY**

I hereby authorise the supervising teachers to obtain any medical or associated assistance which they deem to be necessary should any medical condition or accident occur. I agree to pay any ambulance, medical, dental and/or pharmaceutical expenses incurred on behalf of the above student which are not covered by my personal/family ambulance subscription, medical benefits fund (or travel insurance in the case of overseas travel.)

I further authorise qualified practitioners to perform surgery, administer anaesthetic and/or administer blood transfusions if such an eventuality should arise.

I understand that, should such circumstances arise the supervising teachers will endeavour to contact me by phone in the first instance.

Signature of Parent/Caregiver: _____

Print Name: _____

Phone Contact: Home ( )_____

Work ( )_____

Mobile _____