EMMANUEL ANGLICAN COLLEGE

Learning ~ Living ~ Leading

CONFIDENTIAL HEALTH RECORD

Name of Student:	
Address:	
Phone:	
Age:	
Sex: M/F	
Medicare No:	
Private Health Care Fund:	
Membership No.:	
Next of Kin:	
24 Hour Emergency Contact: Phone:	
Doctor's Name: Doctor's Phone:	

Does your daughter/son/ward suffer from: (Please tick)

Disability		Fits of any type		Heart Condition	
Blackouts		Travel sickness		Epilepsy	
Migraine		Sleep Walking		Diabetes	

Others	…… …… …… …… ……
Normal Treatment of this/these condition:	…… …… ……

Does your daughter/son/ward suffer from allergies? YES/NO
If yes, please give details describing seriousness and nature of reaction and necessary treatment.

Drug related allergies (eg penicillin)	
Environmental allergies (eg food, plants or animals)	

Student's Name: …… Year: ……..

Does your daughter/son/ward suffer any condition/s requiring medication (eg asthma)? YES/NO
Condition:……
……
If yes, please supply details on conditions/s medication and name and contact no. of doctor treating. If ASTHMA please supply MANAGEMENT PLAN.
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……

Does your daughter/son/ward suffer any other disabilities or disorders (eg back problems, poor eyesight)?
YES/NO. If yes, give details
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……
……
……
……

Has your daughter/son/ward suffered any recent illness or injuries? YES/NO
If yes, please give details
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……
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……..

Does your daughter/son/ward suffer from any emotional or behavioural disorders? YES/NO.
If yes, please give details
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……
……

Year of last tetanus booster? ……

Medications: If your daughter/son/ward is on any prescribed medication or drug, please send it with them and ensure it is given to the school staff member in charge. Also make sure that such medication is in the original labeled pharmacy bottle with directions and be accompanied by written instructions on name, dosage and times to be taken. Only the medication required for the duration of the camp should be sent if possible.
Due to legal constraints, staff or instructors are not permitted to administer analgesics (panadol, aspirin etc) without prior written parental permission.

Dietary Requirements:
……
……
……

Student's Name: …… Year: ……..

I, ……
being parent/legal guardian of the above mentioned participant assume full responsibility for her/his health being such that the activities will in no way aggravate any condition present. If in doubt, medical advice will be sought and followed and provided to the staff conducting the camp. In addition, I understand that the program my daughter/son/ward will be involved in will require physical activities that will expose my daughter/son/ward to risks not normally encountered during their everyday classroom activities. Accepting that risk I hereby indemnify Emmanuel Anglican College, its staff and instructors against any claim for accident or injury to my daughter/son/ward while involved in the program.

I authorise the teacher in charge of the activity to consent, where it is impracticable to communicate with me, to my child receiving such medical or surgical treatment as may be deemed necessary and agree to pay any expenses thus incurred.

Signed:…… **Student Name: ……**

Parent/Guardian (PRINT)……..Date:……..