

MEDICAL CONDITIONS		Treatments/Precautions
Yes <input type="checkbox"/> No <input type="checkbox"/>	Anaphylaxis	<i>If **YES**, additional details **MUST** be completed.</i>
Notes : _____		
Specify Treatment : _____		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Serious Medical Conditions	<i>Please specify</i>
ALLERGIES		Symptoms/Preferred treatment:
Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies	<i>Please specify</i>
Please specify : _____		
MENTAL HEALTH		Details/Treatment:
Yes <input type="checkbox"/> No <input type="checkbox"/>	Concerns/ Diagnosis (please specify)	
PHYSICAL DISABILITY		Please add any relevant/supporting information
Yes <input type="checkbox"/> No <input type="checkbox"/>	Please specify	
SOCIAL/EMOTIONAL DIAGNOSIS		Please add any relevant/supporting information
Yes <input type="checkbox"/> No <input type="checkbox"/>	Autism Spectrum Disorder	
Yes <input type="checkbox"/> No <input type="checkbox"/>	ADHD	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Other (please specify)	
SURGICAL HISTORY		Please add any relevant/supporting information
Yes <input type="checkbox"/> No <input type="checkbox"/>	Please specify relevant history	
ONGOING MEDICATIONS		List summary
Yes <input type="checkbox"/> No <input type="checkbox"/>	Prescribed Medications	
List Medications : _____		
Dosage Times & Amounts : _____		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Medications	
CONSENT		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Photograph Permission/ Media Consent	<i>I have read the Student Photograph Permission and Media Consent Note and I give my consent</i>
Yes <input type="checkbox"/> No <input type="checkbox"/>	Technology Agreement	<i>I have read the Technology Agreement and I give my consent</i>
Yes <input type="checkbox"/> No <input type="checkbox"/>	Head Lice Checks	<i>I give consent for my child to take part in head lice checks at school if it is deemed necessary</i>
Yes <input type="checkbox"/> No <input type="checkbox"/>	Can Swim	<i>Please provide capability</i>
Swimming Ability 25m :		
<input type="checkbox"/> Easily	<input type="checkbox"/> With Difficulty	
IMMUNISATION		Notes and Dates (if known)
Yes <input type="checkbox"/> No <input type="checkbox"/>	Immunisation Certificate Complete	

IMMUNISATION		Notes and Dates (if known)
Yes <input type="checkbox"/> No <input type="checkbox"/>	Immunisation Certificate Provided	
MEDICAL HISTORY		Notes
Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye Test Test Date : ___ / ___ / ___ Test Result Comments : _____	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Glasses	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Contact Lenses	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Hearing Test Test Date : ___ / ___ / ___ Test Result Comments : _____	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Hearing Aid	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech Test Test Date : ___ / ___ / ___ Test Result Comments : _____	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Other	
OTHER INFORMATION		Please comment if your child requires special
Yes <input type="checkbox"/> No <input type="checkbox"/>	Dietary Requirements	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Miscellaneous	

Parent/Guardian _____

Signature : _____

Date: ___ / ___ / ___

****Please Note:**** It is parents/guardians' RESPONSIBILITY to inform the college of any changes to this information. All sick and injured day students are expected to be collected if parents are notified. If parents are unable to collect, a suitable contact must be arranged by parents.