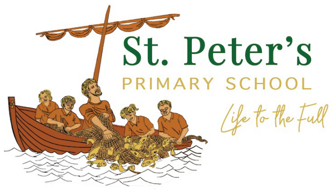

St Peter's Primary School, Bendigo

Confidential Medical Form

Student Name : ______________________ PCG : __________ Year Level: ____

Date of Birth (DD/MM/YYYY) : Male ☐ Female ☐

Address : ______________________ Postcode : ______

Does the family hold a current Health Yes ☐ No ☐ *If yes, please provide the following details:*

Care Card?Health Care Card No : Expiry Date :

Please note you must inform the School of any changes to the above details.

Medicare No : Private Expiry Date : Line No : ☐

Health Cover : Yes ☐ No ☐ Health fund : __________ Membership No : __________

Ambulance Cover : Yes ☐ No ☐ Membership No : __________

Family Doctor : ______________________ Phone: __________

Additional comments/information :

____

MEDICAL CONDITIONS	Treatments/Precautions

Yes ☐ No ☐ Asthma *If **YES**, additional details **MUST** be completed.*

Triggers : ______________________

Last Hospitalisation Date :

Last Hospitalisation Details : ______________________

Asthma Medication : Yes ☐ No ☐

Prevention Medication : ______________________

Relief Medication : ______________________

Symptoms - usual : ______________________

Symptoms - worsening : ______________________

Symptoms - wheezing : ______________________

Symptoms - chest tightness : ______________________

Symptoms - coughing : ______________________

Symptoms - breathing difficulty : ______________________

Action : ______________________

Yes ☐ No ☐ Diabetes *If **YES**, please complete 'Action Form' details.*

Action form : ______________________

Yes ☐ No ☐ Epilepsy *If **YES**, please complete 'Action Form' details.*

Action form : ______________________

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

IMMUNISATION				Notes and Dates (if known)
Yes ☐	No ☐		Immunisation Certificate Provided	
MEDICAL HISTORY				Notes
Yes ☐	No ☐		Eye Test Test Date : Test Result Comments : ____	
Yes ☐	No ☐		Glasses	
Yes ☐	No ☐		Contact Lenses	
Yes ☐	No ☐		Hearing Test Test Date : Test Result Comments : ____	
Yes ☐	No ☐		Hearing Aid	
Yes ☐	No ☐		Speech Test Test Date : Test Result Comments : ____	
Yes ☐	No ☐		Other	
OTHER INFORMATION				Please comment if your child requires special
Yes ☐	No ☐		Dietary Requirements	
Yes ☐	No ☐		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.