Sir David Brand School

Independent Public School

ABN: 12 582 538 74

MEDICAL INFORMATION FORM

Name of Student: _____ **DOB**: _____

Medicare Number: _____

Diagnosis_____

Medical History: _____

(Eg Surgical procedures)_____

PARENT / GUARDIAN

Name (1): _____ **Name** (2) _____

Address: _____ **Address**: _____

_____ _____ ____

Home Ph No: _____ **Home Ph No**: _____

Mob: _____ _____ **Mob**: _____ ___

Email_____ **Email**_____

EMERGENCY CONTACT

Name: _____ **Relation to child**: _____

Home Ph No: _____ **Mob:** _____ _

GP Name: _____ **GP Address**_____

Phone Number: _____ _____

Specialist Names (eg Neuro, Respiratory etc)

1_____ **Phone Number**_____

2_____ **Phone Number**_____

3_____ **Phone Number**_____

Local Area Coordinator Name_____ **Phone Number**_____

Do you have Ambulance cover? Yes Membership Number_____ No

Do you give the School Nurses permission to access your child's medical notes from their GP or PMH? Yes No

Immunisation record sighted Yes No **Immunisations up to date** Yes No

Are there any custody issues? Yes No

Is your child under the Ambulatory Care Coordination Team? Yes No

MEDICATIONS

Does your child take any medications? Yes No **Please write down all medications taken**

Name of Medication	Used For	Time given	Prescribed By

If your child has a temperature or unwell at school, do you give permission for paracetamol to be given?

Yes NO

GASTROSTOMY FEEDS

Does your child have a NGT or gastrostomy tube? Yes No

Dietitian's Name _____ **Dietitian's Phone Number**_____

Last Review_____ **Do you have a copy of current feeding regime?** Yes No

Feeding Regime (Please write down all feeds)

Time	Feed Name and Quantity	Flush

SEIZURES

Has your child been diagnosed with Epilepsy or have seizures Yes No

Does your child require Emergency Medication for seizures? Yes No

If yes, please give description of seizures and complete a seizure management plan:

_____

_____

_____

ASTHMA

Does your child have a diagnosis of asthma? Yes No

If yes, please complete asthma management form.

ALLERGIES

Does your child have any allergies? Yes No

Does your child have any reactions? Yes No

Does your child require medication? Yes No

If yes please describe the reaction and complete an Allergy management plan

_____

_____

Parent / Guardian Signature

_____ Date_____