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|  | Student Medical Information |

SCHOOL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GENDER \_\_Male\_\_Female \_\_\_\_\_\_\_YEAR LEVEL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN WAS YOUR SON/DAUGHTER'S LAST TETANUS BOOSTER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIAL DIETARY REQUIREMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **DOES YOUR SON/DAUGHTER SUFFER FROM ANY OF THE FOLLOWING?**  If yes, please give full details - severity, medication, date of last attack / operation / injury. | |
| (a) Asthma | YES / NO |
| **If YES**, please complete an **Asthma Management Form** | |
| (b) Other Respiratory Problems | YES / NO |
| Details:……………………………………………………………………………………………………………….. | |
| (c) Drug Allergies | YES / NO |
| Details:……………………………………………………………………………………………………………….. | |
| (d) Other Allergies (Food, plants, insects, animals) | YES / NO |
| **If YES**, please complete an **Allergy Reaction Management Form** | |
| (e) Diabetes | YES / NO |
| **If YES**, please complete a **Medical Management Form** | |
| (f) Epilepsy | YES / NO |
| **If YES**, please complete a **Medical Management Form** | |
| (g) Heart Problems | YES / NO |
| **If YES**, please complete a **Medical Management Form** | |
| (h) Blood Pressure ………………………………………………………………………………………………….. | |
| (i) Bed Wetting …………………………………………………………………………………………………………….. | |
| (j) Recent Operations/Injuries ………………………………………………………………………………………… | |
| (k) Swimming Ability Non Swimmer 25m 50m 100m | |

Give full details of any problems that might limit your son/daughter's full participation in any activity (including non-swimmer). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# List any prescribed medication being taken by your son/daughter.

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| Medication | Dosage | Frequency | Doctors Instructions |
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