

LILYDALE HIGH SCHOOL

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CONFIDENTIAL STUDENT MEDICAL FORM

Student's name _____ Form _____

Date of Birth: ____/____/____ Male Female

Date (completing this form): ____/____/____

I supply the following relevant details:

EMERGENCY CONTACTS:

Name of contact	Home Phone No.	Business Phone No.	Mobile Phone No.
Email:			
Emergency contact during the activity (other than the name and number given above)			

Name of medical practitioner	Business Phone No.	After Hours Phone No.
<i>Doctor:</i>		
<i>Dentist:</i>		

Medicare No.:

Valid to: ____/____/____

Are you an ambulance subscriber? Yes No Policy number? _____

Do you have any medical cover other than Medicare? Yes No

If yes, please state cover and policy number:

Medical history

1. Does your child suffer from any form of **ASTHMA**? Yes (complete Asthma Management Form) No
 2. Does your child suffer from any **ALLERGIES**? Yes (complete Allergy Management Form) No
 3. **Does your child have any of the following conditions?**

Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Muscular injuries	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Sight/Hearing disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Phobias	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Migraine headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bleeding disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Ankle/knee/joint problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Psychological conditions	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Infectious disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>				

4. Has your child suffered any serious injuries / illnesses in the past 12 months? Yes No
 5. Does your child wear contact lenses? Yes No
 6. Is your child currently on any medications? Yes No

From 3-6 (above).

Please provide detailed information for any questions to which the answer “Yes” was ticked above (attach a separate sheet if required) eg. type of condition, severity, signs, symptoms medication names and dosage, etc.

The school may require, after reviewing this information, that your child visits a doctor to gain approval to participate. This will be determined after we consult with you regarding the information provided.

7. Details of any dietary considerations. (If vegetarian, does this student eat fish or white meat?)
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8. My child can swim 50 metres: No With a struggle comfortably strongly

9. Date of last tetanus injection _____ (Highly recommended your child has a current inoculation)

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur. I authorise the teacher or any instructor employed on Outdoor Education programs who is caring for/instructing my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for the a teacher/instructor caring for my child to pass this information to a third party (eg. a doctor, hospital) to facilitate the medical treatment of my child.

SIGNED: _____ (Parent/Guardian) DATE: _____