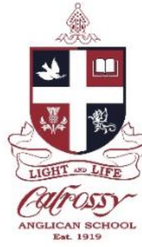
CALROSSY ANGLICAN SCHOOL

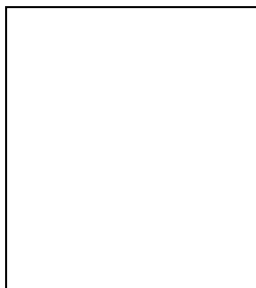


HEALTH, LEARNING & WELLBEING FORM

CONFIDENTIAL MEDICAL CONSENT AND PROCEDURE FORM

- Calrossy Anglican School collects personal information, including sensitive information about students and parents or guardians before and during the course of a student's enrolment at the School. The primary purpose of collecting this information is to enable Calrossy Anglican School to provide schooling for your child.
- Some of the information we collect is to satisfy Calrossy Anglican School's legal obligations, particularly to enable the School to discharge its duty of care.
- Certain laws governing or relating to the operation of schools require that certain information is collected. These include Public Health and Child Protection laws.
- Health information about students is sensitive information within the terms of the National Privacy Principles under the Privacy Act. We ask you to provide medical reports about pupils from time to time.
- The School from time to time discloses personal and sensitive information to others for administrative and educational purposes. This includes to other schools, Government departments, medical practitioners, and people providing services to Calrossy Anglican School, including specialist visiting teachers, (sport, drama) coaches and volunteers.
- If we do not obtain the information referred to above, we may not be able to enrol or continue the enrolment of your child.
- Please refer to the Standard Collection Notice and the Calrossy Anglican School Privacy Policy for detailed information.
- In order to provide the best medical care for your child, it is essential that this medical form remain current.
- Please inform the Health Centre staff when any of your details change.

OFFICE USE



ID Photo

Student's commencement date: _____ / _____ / _____

STUDENT DETAILS

Full Name:

Address Postcode

Date of Birth Female Male

Medicare Number Expiry Date Position on Card

Health Care Card Number Expiry Date

Private Fund Name Type of Cover Membership Number

(e.g. Dental, Optical, Physiotherapy)

Is the student of Aboriginal or Torres Strait Island Origin?

No Yes, Torres Strait Islander Yes, Aboriginal

PARENT / GUARDIAN DETAILS

Parent/Guardian 1 (Name)

Address Postcode

Telephone Home Business Fax

Mobile Email

Parent/Guardian 2 (Name)

Address Postcode

Telephone Home Business Fax

Mobile Email

Emergency Contact In case of emergency, when neither parent can be reached, please contact:

Name

Address Postcode

Telephone Home Business Mobile

Relationship to your child

Student Name: ___________________________________

SECTION 1 – MEDICAL HISTORY

IMMUNISATION RECORDS: Copy of the Blue Book or Records of Immunisation to be attached and returned with these forms. If we do not receive a vaccination record for your child, we consider they are not vaccinated.

* We must advise that should an incident of a vaccine-preventable disease be diagnosed within the School, a student without vaccination protection would be required to be temporarily withdrawn until it was considered safe for that student to return to School.

ALLERGIES

Is your child allergic to any of the following?

Nuts, bee stings, insects, food, medications, plants, pollen, latex, or other. Yes No

If yes, give details.

If yes – please complete the allergy form provided with this form.

Do they require medication for allergies? Yes No

Does your child suffer from anaphylaxis? Yes No

If yes - Has your child been to hospital due to anaphylaxis in the past two years? Yes No

- Does your child have an EpiPen? Yes No

- Please provide the School with an anaphylaxis ASCIA action plan signed by a doctor
- Please supply an EpiPen to the school which will be kept in the Health Centre.
- An Individual Care Plan will be sent to you to complete.

PLEASE NOTE THAT THE SCHOOL CANNOT GUARANTEE A NUT FREE ENVIRONMENT.

However, we do have educational programs for staff in anaphylaxis,
and students are informed about the danger of anaphylaxis.

MEDICAL CONDITIONS

Has your child ever had, or does he/she currently have any of the following conditions:

Epilepsy	Yes	No	Heart Disease	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Glandular Fever	Yes	No	Cancer	Yes	No
Migraine	Yes	No	Headaches	Yes	No	Other	Yes	No

If **yes** to any of the above, please give details and/or any other medical information relating to the condition.

Any other medical concerns?

If yes, please give details.

Student Name: ___________________________________

Does your child have any prior concerns and/or relevant information which could impact their educational experience such as:

Anxiety, depression, eating disorders, self-harm Yes No

If yes, please give details.

Has your child ever received counselling/treatment? Yes No

If yes, please give details.

Any relevant family medical history? Yes No

If yes, please give details.

MEDICATIONS

Does your child take medication?

Please list all prescription and over-the-counter medications below including vitamins, herbal products and creams.

DIET

Has your child been placed on a special diet? Yes No

If yes, please give details.

ASTHMA

Does your child suffer from Asthma (sports-induced or seasonal asthma)? Yes No

If yes
- -Has your child been to hospital due to asthma in the past two years? Yes No
- -Has your child been treated with oral cortisone in the past 12 months? Yes No
- -**Please have your doctor complete the enclosed Asthma Management Plan.**
- -**Please ensure your child has his/her own asthma medication and a spacer.**
- -Primary/Prep asthma medications to be held in the Health Centre.

SPEECH

Does your child have language and/or speech difficulties? Yes No

If yes, please give details.

HEARING

Has your child had a hearing test? Yes No

Is there a history of hearing or ear problems? Yes No

If yes, please give details.

VISION

Have your child's eyes been tested? Yes No

Does your child wear glasses, contact lenses or need any vision aids? Yes No

Any past history of sight problems? Yes No

If yes, please give details.

Is there any other personal or medical information of which staff should be aware? Yes No

If yes, please give details.

Do any of the following apply to your child?

Snoring Sleep Talking Bed Wetting Sleep Walking

SPORT

Does your child have any special requirement for playing sport? Yes No

If yes, please give details.

Please indicate your child's swimming ability.

Can't swim Can swim 25 metres Can swim 50 metres

Student Name: ______________________________

EDUCATIONAL NEEDS

Does your child have a known disability e.g. behavioural, autism, intellectual, physical, health, hearing, vision or emotional?

Yes No

If yes, please give details.

Name of disability

Diagnosed by

Date of Diagnosis **Report available for the School** Yes No

SUPPORT

Does your child receive support from others, e.g. tutoring, psychologist, occupational therapist, speech pathologist? Yes No

If yes, which services are involved e.g. Royal Far West, NSWCER, ASPECT?

Did your child receive support in his/her previous setting? Yes No

What support did your child receive?

Behaviour Yes No **Learning** Yes No **Emotional issues** Yes No

Does your child require particular supervision or support?

To and from school	Yes	No
In the classroom	Yes	No
Moving between classrooms	Yes	No
In the playground	Yes	No
Participation in sport	Yes	No
Excursions	Yes	No

Has your child ever had a problem with school attendance? Yes No

If yes, please give details.

MOBILITY

Are there any issues that need to be addressed by the School? Yes No

Does your child require specialised resources or equipment to do the following?

Access the classrooms ie. ramps Yes No

Access the playground Yes No

Access toilet facilities Yes No

Access general school facilities ie. Farm, Boarding House Yes No

Does your child have any muscular-skeletal disorders? Yes No

If yes, please give details.

COMMUNICATION

Does your child come from a non-English speaking background? Yes No

Does your child require devices for effective communication?
(ie hearing aids, acoustic considerations, glasses, vision aids, scribes, tutors) Yes No

If yes, please give details.

PERSONAL CARE

Can your child manage personal care needs independently?

Toileting Yes No

Dressing Yes No

Eating Yes No

If no, please provide further information.

ADDITIONAL INFORMATION:

How do you rate your child's ability with the following?

Pain

Illness

Compliance

Diet

Separation

Anxiety

Student Name: ___________________________________

SECTION 2 - MINOR ILLNESSES

PRESCHOOL:

* The Director of the Preschool will assess the child and make a report.
* Parent / Guardian will be contacted if further treatment is required.

PRIMARY & SECONDARY STUDENTS:

* Student to report to William Cowper Campus or Brisbane Street Campus Health Centre where their attendance will be recorded.
* Nurse on duty will assess and treat the student as required.
* Parent /guardian of day students will be contacted if further care is required.
* Boarders will be referred to appropriate health professionals if further care is required and parents/guardian notified.

MINOR INJURIES

* Students to report to William Cowper Campus or Brisbane Street Campus Health Centre where assessment and first aid will be administered.
* If injured while playing sport, the student should report to their coach/teacher and an accident / injury form filled out

SECTION 3 - SERIOUS ILLNESS/INJURY REQUIRING DOCTOR OR HOSPITAL

* The parent/guardian will be contacted, if possible, according to the information available on the medical form.
* Staff will assess the student and, if required, the student will be transported to the doctor/hospital.
* In an emergency or on the advice of an attending doctor, the student will be taken by ambulance or other suitable vehicle to the nearest available hospital.
* In the event of accident or sudden illness, there may be times when it is not possible to contact parents/guardian. In such circumstances the School Principal or senior staff member should obtain medical advice and authorise medical treatment, including the administration of anaesthetic for operation or if medical advice indicates it is necessary, for the health and wellbeing of the student.
* Students may be sent home if diagnosed with an infectious or communicable disease such as head lice, mumps, whooping cough, impetigo, ringworm, gastritis or chickenpox.

SECTION 4 – MEDICATION PROCEDURES

Prescription and Restricted medications:

Medication procedures apply to THE WHOLE SCHOOL.

* It is imperative that parents inform designated staff/nurse of all medication taken by students.
* All medication taken during the day must be stored at the Health Centre.
* Assistance will be given by the staff/nurse to administer prescription medication when documentation is received from parent/guardian.
* All prescription medication will be administered only if the container states student’s name, doses, time of administration and is labelled in the original container.
* All medication administered by school staff/nurse will be recorded.
* Medications to be held at the Health Centre at parent or parents’ request are: e.g. EpiPen, Glucagon injection, Ritalin, Ventolin, short term medications e.g. antibiotic
* Written individual health care plans are put in place for students who have epilepsy, Type 1 diabetes, severe asthma, mental health, allergies and anaphylaxis.
* No medications are to be kept in the boarding houses by students without the approval of the nursing staff.

NON-PRESCRIPTION “over the counter” MEDICATIONS

* **NO** medication may be given to students unless authorised by parents in writing.
* Any other medication will need to be supplied (in original container) to the staff with the students’ name and instructions for use in writing by parent/guardian.

PREP STUDENTS

Please give details of specific medication to be held at the preschool/prep:

Signature of Parent / Guardian Date

PRIMARY STUDENTS

* The following non-prescription medication and lotions are in the first aid centre for the treatment of minor conditions and illnesses.
* Please SIGN beside the MEDICATION which you authorise staff to administer to your child if required:

PANADOL (PARACETAMOL) Signature

RID Signature

BETADINE Signature

STINGOSE Signature

Please give details of a specific medication to be held at the Health Centre.

Signature of Parent/Guardian Date

SECONDARY STUDENTS

***** The following non-prescription medications are held in the Health Centre for the relief of minor pain, coughs, colds, fever and period pain.
* The following list is for all Secondary students.
* Please sign below that you authorise us to administer to your child if required.

Paracetamol	Dry cough mixture	Aloe Vera gel	Antifungal Cream
Zaditen eye drops	Chesty cough mixture	Stingose	Burn aid
Calamine Lotion	Bonjela Gel	Ventolin	Vitamin C
Naprogesic	Eno	Betadine	S.M. 33 Liquid
Sudafed	Hydrolyte	Vicks	Lanolin
Kwells	Demazine	Hydrogen Peroxide 3%	Sunscreen
Throat Gargles	Aqua Ear Drops	Hirudoid cream	Imodium
Telfast 60mgs	Cerumol Ear Drops	Solosite gel	Buscopan
Telfast 120gms	Anti-Inflammatory Gel	SOOV	

Parent Name Parent Signature

Child's Doctor

Address Telephone

Child's Dentist

Address Telephone

Student Name: ____________________________________

MEDICAL CONSENT AND ENROLMENT AGREEMENT FORM

For my/our child while he/she is at the School, on excursion or involved in any School activity.

- I/we acknowledge all the School medical and health policies and shall uphold them.
- I/we agree to inform the School of any changes to information contained in this form as and when necessary amendments are required.
- I/we agree to keep the School informed, in writing, of any current court orders relating to the custody/access/residence of my child.
- I/we agree that School staff may administer authorised medications to my/our child, with (our) written consent.
- I/we agree that School staff may administer first aid to my/our child.
- I/we acknowledge responsibility for notifying the School if my/our child has an infectious or communicable disease.
- I/we give authority for the School to seek urgent medical, dental, hospital and/or ambulance services for my child.
- I/we understand this consent shall remain valid unless withdrawn and notified (by myself/us) in writing to the School.

Signature of Parent/Guardian | Signature of Parent/Guardian

Date | Date

Student Name: ________________________________

Students with allergies

This form is to be completed by the parent/guardian of a student with an allergy and returned to the school. The purpose of collecting this information is to identify students who are at risk of a severe allergic reaction. Information provided on this form will be used to assist the school in determining what action needs to be taken in relation to a student with an allergy.

(Student Name)

has an allergy/allergies to

Please complete the questions below and return to the school.

1. A doctor has diagnosed my child with an allergy to:

   Insect sting/bite (Provide details below.)

   Medication (Provide details below.)

   Food:

☐	Peanuts	Yes	No
☐	Nuts. Please specify:	Yes	No
☐	Fish	Yes	No
☐	Shellfish	Yes	No
☐	Soy	Yes	No
☐	Sesame	Yes	No
☐	Wheat	Yes	No
☐	Milk	Yes	No
☐	Egg	Yes	No
☐	Other. Please specify:		

Latex	Yes	No
Other. Please specify:	Yes	No

2.	My child has been hospitalised with a severe allergic reaction	Yes	No
3.	My child has been prescribed an adrenaline autoinjector (EpiPen® or Anapen®)	Yes	No
4.	My child has an ASCIA Action Plan for Anaphylaxis[6] (please attach this and return the form)	Yes	No

Completed by

Parent/Guardian Name Date

Signature:

[6] Each time your child is prescribed a new adrenaline autoinjector the doctor will issue an updated ASCIA Action Plan for Anaphylaxis. It is important that this is the plan provided to the school

My Asthma Action Plan

When my asthma is WELL CONTROLLED

- No regular wheeze, or cough or chest tightness at night time, on waking or during the day
- Able to take part in normal physical activity without wheeze, cough or chest tightness
- Need reliever medication less than three times a week (except if it is used before exercise)
- Peak Flow* above [ ]

What should I do?

Continue my usual treatment as follows:

Preventer

Reliever

Combination Medication

Always carry my reliever puffer

When my asthma is GETTING WORSE

- At the first sign of worsening asthma symptoms associated with a cold
- Waking from sleep due to coughing, wheezing or chest tightness
- Using reliever puffer more than 3 times a week (not including before exercise)
- Peak Flow* between

[ ] and [ ]

What should I do?

Increase my treatment as follows:

See my doctor to talk about my asthma getting worse

When my asthma is SEVERE

- Need reliever puffer every 3 hours or more often
- Increasing wheezing, coughing, chest tightness
- Difficulty with normal activity
- Waking each night and most mornings with wheezing, coughing or chest tightness
- Feel that asthma is out of control
- Peak Flow* between

[ ] and [ ]

What should I do?

Start oral prednisolone (or other steroid) and increase my treatment as follows:

See my doctor for advice

How to recognise LIFE-THREATENING ASTHMA

Dial 000 for an ambulance and/or 112 from a mobile phone if you have any of the following danger signs:

- extreme difficulty breathing
- little or no improvement from reliever puffer
- lips turn blue

and follow the Asthma First Aid Plan below while waiting for ambulance to arrive.

A serious asthma attack is also indicated by:

- symptoms getting worse quickly
- severe shortness of breath or difficulty in speaking
- you are feeling frightened or panicked
- Peak Flow* below [ ]

Should any of these occur, follow the Asthma First Aid Plan below.

Asthma First Aid Plan

1 Sit upright and stay calm.

2 Take 4 separate puffs of a reliever puffer (one puff at a time) via a spacer device. Just use the puffer on its own if you don't have a spacer. Take 4 breaths from the spacer after each puff.

3 Wait 4 minutes. If there is no improvement, take another 4 puffs.

4 If little or no improvement **CALL AN AMBULANCE IMMEDIATELY (DIAL 000** and/or **112** from mobile phone) and state that you are having an asthma attack. Keep taking 4 puffs every 4 minutes until the ambulance arrives.

See your doctor immediately after a serious asthma attack.

Dr name: ....Ph.................................Signature...

Parent/Carer ....Ph...

Name:... Date:... Best Peak Flow*:......................... Next Doctor's Appointment:...

* Not recommended for children under 12 years

My Asthma Action Plan

This written Asthma Action Plan will help you to manage your asthma.
Your Asthma Action Plan should be displayed in a place where it can be seen by you and others who need to know.
You may want to photocopy it.

Australian Government
Department of Health and Ageing

What happens in asthma?

Asthma inflames the airways. During an asthma attack, the air passages (airways) of the lungs become inflamed, swollen and narrowed. Thick mucus may be produced and breathing becomes difficult. This leads to coughing, wheezing and shortness of breath.

Asthma Triggers

Common asthma triggers are house dust mite, pollens, animal fur, moulds, tobacco smoke, and cold air. It is unusual but some foods may trigger asthma attacks.

Exercise is a common asthma trigger but can be well managed with pre-exercise medication and warm-up activities.

My known asthma triggers are:

....

....

....

....

Before exercise I need to warm up properly and take the following asthma medication:

....

....

....

....

Useful telephone numbers

- Asthma Foundation 1800 645 130 for information and advice about asthma management
- My pharmacy: ....

How your preventer medicine helps

Your preventer medicine reduces the redness and swelling in your airways and dries up the mucus. Preventers take time to work and need to be taken every day, even when you are well.

Preventer medications are: Qvar (beclomethasone), Flixotide (fluticasone), Intal Forte CFC-Free (sodium cromoglycate), Pulmicort (budesonide), Singulair (montelukast) and Tilade CFC-Free (nedocromil).

How your reliever medicine helps

Your reliever medicine relaxes the muscles around the airways, making the airways wider and breathing easier. It works quickly to relieve asthma symptoms, so it is essential for asthma first aid.

Reliever medications are: Airomir, Asmol, Epaq and Ventolin (all brands of salbutamol) and Bricanyl (terbutaline).

How your symptom controller helps

Symptom controllers can help people who still get symptoms even when they take regular preventer medicines. If you need a symptom controller, it should be taken with your preventer medication. It should not be taken instead of a preventer.

Like your reliever medicine, your symptom controller helps widen the airways. But while your reliever works for around 4-6 hours, symptom controllers work for up to 12 hours at a time. However, they are not good for quick relief of symptoms so they should not be used for asthma first aid.

Symptom controllers are: Foradile and Oxis (both brands of eformoterol), and Serevent (salmeterol).

There are **combination medications** that combine a symptom controller and a preventer in one puffer.

Combination medications are: Seretide (fluticasone and salmeterol) and Symbicort (budesonide and eformoterol).

Your GP can advise you on the availability under the Pharmaceutical Benefits Scheme of the drugs mentioned above.

My medications are

Preventer

....

Reliever

....

Symptom Controller

....

Combination Medication

....

Other Comments

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