**Our Lady of Fatima Primary School**

# STUDENT MEDICAL INFORMATION

**THIS FORM ONLY NEEDS TO BE COMPLETED AND RETURNED IF THERE ARE ANY MEDICAL CONCERNS RELATING TO YOUR CHILD.**

## STUDENT DETAILS

Surname: _____ Christian Name: _____

Date of Birth: _____ / _____ / _____ Gender: Male ☐ Female ☐

Home Address:

_____

_____ Postcode: _____

Contact Number: _____

## MEDICAL DETAILS

Medical Alert: ☐ Yes, please comment ☐ No

Medical Comment: _____

_____

_____

_____

## MEDICAL PRACTITIONER & HEALTH FUND DETAILS

Name of Student's Doctor: _____

Telephone No. of this Doctor: _____

Ambulance Subscription ☐ Yes ☐ No

## EMERGENCY CONTACTS

Name: _____ Contact No: _____

Relationship to student: _____

Please confirm/list the following details:

- Any physical, medical or intellectual disability/illness you child suffers. Refer to note (A) over the page.
- Medication, including dosage. Refer to note (A) over the page.
- Known allergies as shown above. Refer to note (B) over the page.
- List other information of a personal nature of which you consider the Sick Bay attendant should be aware.
- List any reason why your child should not participate in normal sporting/camp activities

**(A)** Does your child suffer any of the following: (if so, please give details in the space provided and/or append any additional information that will be of use when caring for you child, including details of medication and dosage/s prescribed)

| | | |
|---|---|---|
| ☐ BLACKOUTS | ☐ TRAVEL SICKNESS | ☐ DIABETES |
| ☐ BED WETTING | ☐ MIGRAINS | ☐ ASTHMA |
| ☐ HEART CONDITION | ☐ RESPIRATORY PROBLEMS | ☐ OTHER |
| ☐ SEIZURES | ☐ SLEEPWALKING | |
| ☐ FITS OF ANY KIND | ☐ DIZZY SPELLS | |

Fully explain any of the previous section you marked or other problems your child has. Please attach letter if necessary.

_____

_____

**(B) ALLERGIES/SPECIAL REQUIREMENTS**

Does your child have any allergies to any of the following?

| | |
|---|---|
| ☐ PENICILLIN | ☐ ANY FOODS |
| ☐ OTHER DRUGS | ☐ OTHER ALLERGIES |

What special care is recommended? Details please:

_____

_____

_____

**TETANUS IMMUNISATION:** Last tetanus immunisation was: _____/_____/_____

**If medication is to be administered at school:** ***All medication must be in its original packaging and clearly labelled with your Child's name. The medication will be kept in sickbay. Please take note of the use by date.***

MEDICATION TO BE KEPT IN SICKBAY – DETAILS PLEASE: _____

_____

_____

**SIGNATURE OF PARENT/GUARDIAN:** _____ **DATE:** _____/____/____

**ACCIDENT DECLARATION:** In the event of illness or injury to my child whilst at school, on an excursion/camp, or travelling to or from school, I authorise the Principal or senior staff member in charge of my child, where it is impracticable to communicate with me, to consent to emergency medical arrangements on my behalf as are deemed necessary by a qualified medical practitioner. Such consent includes anaesthetics, blood transfusions and operations.

**SIGNATURE OF PARENT/GUARDIAN:** _____ **DATE:** _____/____/_____

## SCHOOL ASTHMA ACTION PLAN

This record is to be completed by parents/carers in consultation with their child's doctor (General Practitioner). Please tick the appropriate box and print your answers clearly in the blank spaces where indicated. This school is collecting information on your child's asthma so we can better manage asthma while your child is in our care. The information on this plan is confidential. All staff who care for your child will have access to this information. It will only be distributed to them to provide safe asthma management for your child at school. The school will only disclose this information to others with your consent if it is to be used elsewhere. Please contact the school at any time if you need to update this Plan or you have any questions about the management of asthma at school. If no Asthma Action Plan is provided by the parent/carer, the staff will treat asthma symptoms as outlined in the Victorian Schools Asthma Policy 2003.

Student's Name: _____ Gender M ☐ F ☐

Age: _____ Date of Birth _____ / _____ / _____ Year/Class _____

Emergency Contact (e.g. Parent/Carer) _____

Relationship: _____

Phone (H) _____ (B/H) _____ Mobile _____

Doctor's Name: _____

Ambulance Subscriber Yes ☐ No ☐ Subscriber No. _____

**PHOTO**
(optional)

### USUAL ASTHMA ACTION PLAN

| Usual signs of child's asthma<br>Increasing signs of : | Worsening signs of child's asthma | What triggers the child's asthma? |
|---|---|---|
| ☐ Wheezing | ☐ Wheezing | ☐ Exercise |
| ☐ Tightness in chest | ☐ Tightness in chest | ☐ Colds/Viruses |
| ☐ Coughing | ☐ Coughing | ☐ Pollens |
| ☐ Difficulty in breathing | ☐ Difficulty in breathing | ☐ Dust |
| ☐ Difficulty in speaking | ☐ Difficulty in speaking | |

Other Triggers (please describe)

_____

_____

Does you child need assistance taking their medication? Yes ☐ No ☐

**Asthma medication requirements usually taken at school:** (including preventers, symptom controllers, combination medication, medication before exercise)

| Name of Medication | Method (e.g. puffer & spacer, tub haler) | When, and how much? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Is your child on regular preventer medication taken at home? Yes ☐ No ☐

## ASTHMA FIRST AID PLAN

Please tick preferred First Aid Plan:

☐ ***Victorian Schools Asthma Policy for Asthma First Aid***
(section 4.5.7.8 of Department of Education and Training's Victorian Government School's Reference Guide.)

1. Sit the student down and remain calm to reassure the student. Do not leave the student alone.
2. Without delay shake a blue reliever puffer (names include Ventolin, Airomir, Asmol or Eqaq) and give 4 separate puffs, through a spacer (spacer technique – 1 puff / take 4 breaths from spacer, repeat until 4 puffs have been given).
3. Wait 4 minutes. If there is no improvement, give another 4 separate puffs, as per step 2.
4. Wait 4 minutes. If there is no improvement, call an ambulance (dial 000) immediately and state that "a student is having an asthma attack"
5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

If at any time the student's condition worsens, call an ambulance immediately.

OR

☐ ***Student's Asthma First Aid Plan (if different from above)***

_____

_____

_____

_____

_____

_____

- Please notify me if my child regularly has asthma symptoms at school.
- Please notify me if my child has received asthma first aid.
- In the event of an asthma attack at school, I agree to my son/daughter receiving the treatment described above.
- I authorise school staff to assist my child with taking asthma medication should they require help.
- I will notify you in writing if there are any changes to these instructions.
- I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent/Guardian Signature: _____ Date: ___/___/___

Doctor's Signature: _____ Date: ___/___/___

Doctor's Phone Number: _____

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly Schools Program and asthma management please contact: Asthma Victoria on (03) 9326 7088 or Toll Free 1800 645 130 or visit their website: www.asthma.org.au