

DSHS Bunya Campus Medical Form



STUDENT DETAILS					
SURNAME:		GIVEN NAMES:			
DATE OF BIRTH:		MOBILE NO:			
EMERGENCY CONTACTS					
NAME:		RELATIONSHIP:			
PHONE NUMBER:		MOBILE NO:			
NAME:		RELATIONSHIP:			
PHONE NUMBER:		MOBILE NO:			
HEALTH INSURANCE DETAILS <i>(all cards are to be photocopied for Student File)</i>					
MEDICARE NO:		EXPIRY:		POSITION:	
HEALTH CARE CARD NO:		EXPIRY:			
PRIVATE HEALTH COMPANY: <i>(if applicable)</i>					
MEMBER NUMBER, POSITION & EXPIRY:					
MEDICAL HISTORY					
ALLERGIES AND REACTIONS: <i>(please list details and dates if applicable)</i>					
SURGICAL / MEDICAL PROCEDURES: <i>(please list details and dates if applicable and include fractures/broken bones, removal of moles/warts, dental operations, major illness and hospitalisation)</i>					

IMMUNISATION	DATE RECEIVED
Tetanus / Diphtheria	
Measles / Mumps / Rubella	1 st 2 nd
Hepatitis B	1 st 2 nd 3 rd
Q Fever	
Chicken Pox	1 st 2 nd
Meningococcal	
Other Immunisations <i>(Please list)</i>	

MEDICAL CONDITIONS: *(Yes / No and if Yes provide details please)*

CONDITION	YES/NO	CONDITION	YES/NO	CONDITION	YES/NO	CONDITION	YES/NO
Sight		Hearing		Heart		Glandular Fever	
Lungs		Measles		Mumps		Ross River Fever	
Diabetes		Epilepsy		Hay Fever		Dengue Fever	
Kidneys		Asthma		Sinus		Chicken Pox	

Any additional medical information:

Are you currently receiving or recently received <u>ongoing</u> care by any of other the following specialists for a medical condition?			
Doctor	Yes / No	Physiotherapist	Yes / No
Chiropractor	Yes / No	Psychiatrist	Yes / No
Psychologist	Yes / No	Counsellor	Yes / No
Do you currently use any of the following?			
Prescription Medication (see below)	Yes / No		
Non-Prescription Medications	Yes / No		
I understand that it is the responsibility of parent / guardian to provide long-term medications requirements via WEBSTER PACKAGING .			
I understand that it is the parent / guardian responsibility to negotiate with a pharmacy to arrange Webster Packs for a full term supply or weekly delivery of Webster Pack to Campus.			
If you have ticked <u>YES</u> to any of the above, please provide further details including type, dose and frequency of use:			
MEDICAL DECLARATION			
For those students who are active sports people and suffer from muscular related injuries, please be advised that DSHS Bunya Campus does not provide strapping, sports bands or supports eg knee guards etc.			
Do you have any psychological and / or physical condition/s which could influence the health and safety of those around you in a classroom, doing farm work, dining and residential situations?			
YES / NO			
If yes please provide details:			
I hereby advise that the information contained in this document is true and correct and I understand that failure to disclose a condition is a serious threat to Workplace Health and Safety and may endanger the lives of other students and Residential Staff.			
Parent / Guardian Signature		Date	
Student Signature		Date	

GENERAL TREATMENT:	I authorise DSHS Bunya Campus First Aid Officers to discuss injury/illness with student and where necessary organise follow up care. This will include making medical appointments as necessary. I understand that for students under 16 years of age, where possible, consent will be sought prior to the appointment. I am aware that not all Medical Practices bulk bill and if required, I agree to pay any medical appointment my student attends at a Practice that doesn't bulk bill.
	<i>Parent / Guardian Signature & Date</i>
	<i>Student Signature & Date</i>
MEDICATIONS:	I authorise DSHS Bunya Campus staff, in accordance with packaging directions, to administer prescribed medications as determined by a treating medical practitioner. If long term medication, then I understand that Webster Packaging will be used (I acknowledge that some Pharmacies may charge a packaging fee). I authorise DSHS Bunya Campus staff, in accordance with packaging directions, to administer "over the counter" medications as determined by a Pharmacist without a Doctor's prescription.
	<i>Parent / Guardian Signature & Date</i>
	<i>Student Signature & Date</i>
RELEASE OF INFORMATION:	I authorise DSHS Bunya Campus staff to discuss my injury/illness/results with the treating medical professional (eg doctor, physiotherapist, chiropractor). I understand this consent is required to assist with the student's work/training schedule. All information will be treated as confidential and will remain with the DSHS Bunya Campus.
	<i>Parent / Guardian Signature & Date</i>
	<i>Student Signature & Date</i>
EMERGENCY TREATMENT:	I authorise DSHS Bunya Campus to act/sign on my behalf in authorising anaesthetics and any other medical treatment, should this be necessary in the case of an emergency.
	<i>Parent / Guardian Signature & Date</i>
	<i>Student Signature & Date</i>