ST JOSEPH'S SCHOOL WAROONA

2020 CAMP MEDICAL INFORMATION SHEET

**Please note: The information provided on this sheet will be treated with strict confidentiality. Only Mr O’Dwyer, Mrs Gorman and Mrs Fuller will have access to it.**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st Contact PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Contact PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACT IF NO ONE ELSE CAN BE REACHED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL INSURANCE? YES/NO NAME OF FUND AND MEMBER #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMBULANCE COVER? YES/NO MEDICARE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOCTOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TETANUS BOOSTER IN THE LAST 12 MONTHS? YES/NO \_\_\_\_\_\_\_\_

PLEASE CIRCLE ANY MEDICAL CONDITIONS BELOW YOUR CHILD SUFFERS FROM:

|  |  |  |  |
| --- | --- | --- | --- |
| Heart Problems | YES/NO | Diabetes | YES/NO |
| Asthma/Respiration Issues | YES/NO | Blood Pressure | YES/NO |
| Bed Wetting | YES/NO | Epilepsy | YES/NO |
| Drug Allergies | YES/NO | Phobias | YES/NO |
| Food Allergies | YES/NO | Recent Illness or operation | YES/NO |
| Other Allergies | YES/NO | Other Issues | YES/NO |
| Anaphylaxis/EpiPen | YES/NO |  |  |

Please give details of anything marked “YES” above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dietary Requirements:

Nuts Egg Gluten Free Diabetic Vegan Vegetarian

Lactose Dairy Preservatives Religious Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give details of any medication being taken by your child including dosage, frequency etc.

***ALL MEDICATIONS MUST BE CLEARLY LABELLED AND GIVEN TO THE TEACHERS.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you would like us to know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorise the teacher in charge, or a representative, to obtain medical attention as may be deemed necessary and I understand that I am responsible for the costs. I further authorise qualified practitioners to administer anaesthetic and blood transfusions if the necessity arises.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_