

# MEDICAL CONSENT & PROCEDURE FORM

## BOARDING STUDENTS



### SECTION 1: STUDENT AND FAMILY DETAILS

#### STUDENT DETAILS

Surname: \_\_\_\_\_

Given names: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Current school year level: \_\_\_\_\_

Boarding house: \_\_\_\_\_

Medicare number: \_\_\_\_\_

Position on card: \_\_\_\_\_

Expiry (month & year): \_\_\_\_\_

Private Health Fund provider: \_\_\_\_\_

#### Doctor's details

Name: \_\_\_\_\_

Contact number: \_\_\_\_\_

#### Dentist/Orthodontist details:

Name: \_\_\_\_\_

Contact number: \_\_\_\_\_

#### Emergency contact details:

Name: \_\_\_\_\_

Contact number: \_\_\_\_\_

Address: \_\_\_\_\_

Please state briefly any health issues, medical alerts or special needs of which staff need to be aware:

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#### PARENT/GUARDIAN 1 DETAILS

Surname: \_\_\_\_\_

Given names: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

#### PARENT/GUARDIAN 2 DETAILS

Surname: \_\_\_\_\_

Given names: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

## SECTION 2: MEDICAL DETAILS

Is your child's immunisation up to date? ☐ Yes ☐ No

### IMMUNISATION RECORD

Year of last Tetanus or ADT booster: \_\_\_\_\_

Year of last Polio booster: \_\_\_\_\_

Year of last Measles/Mumps/Rubella: \_\_\_\_\_

Year of last Hepatitis B vaccination: \_\_\_\_\_

☐ I have attached a copy of my child's Immunisation Certificate.  
History Statements can be obtained by logging into Medicare online (via MyGov) or you can visit your local Medicare office or call 1800 653 809.

### CHILDHOOD DISEASES

Please tick boxes if your child has had any of the following illnesses:

- |  |   |  |                                |
|--|---|--|--------------------------------|
| <input type="checkbox"/> Chicken Pox                   | <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Measles                       | <input type="checkbox"/> Rubella (German Measles) | <input type="checkbox"/> Glandular Fever | <input type="checkbox"/> Croup |
| <input type="checkbox"/> Other (please specify): _____ |   |  |                                |

### ASTHMA HISTORY

Does your child suffer from Asthma? ☐ Yes ☐ No

**If yes, please answer the following:**

Has your child been to hospital due to asthma in the past 12 months? ☐ Yes ☐ No

Has your child been treated with oral cortisone in the past 12 months? ☐ Yes ☐ No

Does your child have an action plan? If yes, please enclose a copy. ☐ Yes ☐ No

Name of current reliever: \_\_\_\_\_

Name of current preventer: \_\_\_\_\_

Other medication taken for Asthma: \_\_\_\_\_

### MEDICAL HISTORY

Please tick if your child has suffered from any of the following:

- ☐ Diabetes ☐ Epilepsy ☐ Attention Deficit Disorder

Please note any other health issues that the School should be aware of.  
For example, special needs or disability, learning difficulties/problems, fainting, Hepatitis B carrier, incontinence, etc.

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### COUNSELLING OR PSYCHOLOGICAL ISSUES

Please describe any counselling or psychological issues that your child has or has had that the School should be aware of:

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### PRESCRIPTION MEDICATION

Please list any prescription medications, dosage and frequency that your child is currently taking:

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### ALLERGIES AND TREATMENT REQUIRED

Medication:

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Food:

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Insects:

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Other:

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ASCIA Action Plan supplied:

☐ Yes ☐ No

### OPERATIONS AND OTHER INJURIES

Please describe any operations your child has had or any other injuries that the School should be aware of:

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### CURRENT TREATMENTS

Please describe any current treatments that your child is undergoing that the School should be aware of:

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## HEARING OR SIGHT DIFFICULTIES

Does your child wear glasses?

☐ Yes ☐ No

Please provide further detail below regarding your child's use of glasses (e.g. short or long sided, for reading only or for use with computers, coloured glasses etc.):

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Does your child have any hearing difficulties?

☐ Yes ☐ No

If yes, please provide further detail below:

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### SECTION 3: SCHOOL PROCEDURE (ACCIDENT OR ILLNESS)

#### MINOR AILMENTS

- The student will report to the Health Clinic where their attendance will be recorded on the daily register.
- The registered nurse on duty will assess and treat the student as required. If further care is required for Boarders they will be referred to the appropriate health professionals.

#### MINOR INJURIES

- Student to report to the Health Clinic where assessment and first aid will be administered.
- If the student is injured while playing sport they should report to the coach/teacher in the first instance and then to the registered nurse on duty.
- Treatments will be documented in personal medical records and if presented, the student's diary will be stamped.

#### SERIOUS ILLNESS/INJURY REQUIRING A DOCTOR OR HOSPITAL

- The parent/guardian will be contacted if at all possible according to the information available on the medical form.
- The school nurse will be called to the site of the injury/illness and/or the student transferred to the Health Clinic where first aid will be administered.
- The nurse on duty 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 hospital.

#### MEDICATION PROCEDURES

- Parents are requested to inform the Health Clinic of any medications being taken by students.
- All medications taken during the school day should be stored in the Health Clinic unless other arrangements are made with the nursing staff.
- All medications administered by the school nurse will be recorded.

#### Non-prescription or 'over the counter' medications:

The following non-prescription medications are held in the Health Clinic for the relief of minor pain, coughs, cold and fever. Please sign beside each medication that you authorise us to administer to your child if required:

- |                                    |  |  |  |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Panadol   | <input type="checkbox"/> Cold sore cream   | <input type="checkbox"/> Acetopt eye drops     | <input type="checkbox"/> Senegar cough mixture   |
| <input type="checkbox"/> Nurofen   | <input type="checkbox"/> Anti-fungal cream | <input type="checkbox"/> Auralgin ear drops    | <input type="checkbox"/> Rikodene cough mixture  |
| <input type="checkbox"/> Disprin   | <input type="checkbox"/> Gastrolyte        | <input type="checkbox"/> Anti-inflammatory gel | <input type="checkbox"/> Brondecon cough mixture |
| <input type="checkbox"/> Panadeine | <input type="checkbox"/> Throat lozengers  | <input type="checkbox"/> Throat gargle         | <input type="checkbox"/> Hirudoid                |
| <input type="checkbox"/> Sudafed   | <input type="checkbox"/> Mylanta           | <input type="checkbox"/> Heat Rub              |  |

Please list below any other non-prescription medications that your child may need and name of the condition being treated.

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For the relief of minor allergies the following medications may be given. Please sign beside each medication that you authorise us to give your child if required.

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|------------------------------------|----------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Claratyne | <input type="checkbox"/> Telfast | <input type="checkbox"/> Phenergan | <input type="checkbox"/> Sudafed |
|------------------------------------|----------------------------------|------------------------------------|----------------------------------|

**Prescription and Restricted Medications:**

- Assistance will be given by the school nurse in the administration of prescription medication, when requested in writing by parents/guardians or as prescribed by a doctor.
- Assistance will be given by the school nurse in the administration of Restricted medication (such as Ritalin, Dexamphetamine) after receiving documentation from the doctor or parent/guardian.
- Instructions regarding changes to the original dosage of long term or Restricted medications must be in writing from the doctor or parent/guardian.
- The school nurse may only administer or assist with the administration of any medication if the medication provided is its original container with label clearly displaying the student's name and the required dosage.
- The school nurse will arrange for the local pharmacy to fill prescriptions for boarders.
- All medications will be stored in a locked cupboard in the Health Clinic.

**SECTION 4: PARENT/GUARDIAN CONSENT**

I/We \_\_\_\_\_ (Parent/Guardian please print name)

being the parent/guardian of \_\_\_\_\_ (Please print student name)

Consent to the administration of medicines specified in Section One and any others as notified by me/us in writing as required and also provide the information as requested in Section Two of this form.

I/We authorise you, in the event of injury to / or illness of our child, to follow the procedure(s) set out in Section One of this consent.

I/We undertake to inform you of any changes to the information contained in this form as and when necessary. This consent shall remain valid unless withdrawn and notified by myself/us in writing to the School.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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**PLEASE RETURN THIS FORM TO:**

Admissions Office  
Kinross Wolaroi School  
Locked Bag 4, Orange NSW 2800

For further information please contact the School on 02 6392 0300