Guildford Grammar School

FOUNDED 1896

STUDENT HEALTH RECORD

NEW STUDENTS: It is a condition of enrolment that a parent/guardian must complete and return this health record prior to a student entering the School. Failure to complete the documentation in it's entirety will mean a student's enrolment will be deferred.

HOUSE/QUARTER _____ YEAR OF ENTRY _____

PART 1 TO BE COMPLETED BY PARENT OR GUARDIAN

Student's Full Name: _____ DOB _____

Home Address _____

Mother/Guardian _____ Home Ph _____

Address if different from child's: _____

Work Ph: _____ Mob _____ Email _____

Father/Guardian _____ Home Ph _____

Address if different from child's: _____

Work Ph: _____ Mob _____ Email _____

HEALTH FUND DETAILS ***Must be completed***

Medicare Number: _____ Position: _____ Expiry: _____

Name of Private Fund: _____ Policy Number: _____

Ancillary Cover: **Yes/No** Hospital Cover: **Yes/No**

Health Care Card Number: _____

EMERGENCY CONTACT **Please list an alternative person who can be contacted if the School is unable to contact you.**

Name: _____ Relationship to Student: _____

Address: _____

Home Ph: _____ Mob _____ Work Ph _____

IMMUNISATION DETAILS

Has your child been fully vaccinated according to the Health Department recommended Immunisation Schedule? **Yes/No**

(Please provide a photocopy of your child's immunisation record)

Date of last Tetanus immunisation: _____

EMERGENCY CONSENT

*In the event of an emergency the school will make **every effort** to contact a parent or nominated person in the first instance. However, unless advised in writing to the contrary, if such contact **cannot** be made, the school will arrange medical and/or dental treatment or ambulance transport when considered necessary.*

MEDICATION CONSENT

I authorise the School Nurse or camp/excursion supervisor to administer over the counter medication (Schedule 2 and 3 medications) and any medication prescribed by a medical or dental practitioner to the student, as deemed necessary.

If the child boards at the school, I also authorise the Person on Duty to administer over the counter medication and any medication prescribed by a medical or dental practitioner to the student as deemed necessary under the direction of the School Nurse.

PRIVACY CONSENT

I authorise the School to collect the information contained in this form, and to disclose that information to the School's employees, medical and emergency workers and the above mentioned parents or guardians, for the purposes of making those necessary aware of medical risks to which the student might be subject.

The school collects and uses personal information subject to the requirements of the Privacy Act, and in accordance with the School's Privacy Statement. If you would like a copy of this, please contact the school and request one.

Signature of Student **Date:**

(The student should also sign this consent if over 15 years of age) _____ _____

Signature of Parent **Date:**

_____ _____

PAST MEDICAL/SURGICAL HISTORY *(Please attach copies of any significant specialist's reports in relation to any conditions or ongoing treatment. Please use space on Page 3 if necessary for any additional information.)*

Has your child had any operations in the past? *If yes please state operation and date.*

_____
_____
_____

Has your child had any serious accident or injury? *Please specify and provide dates.*

_____
_____
_____

Does your child suffer with any condition which may restrict their activities at school, that staff should be aware of or may pose a risk of injury or infection to others with whom they may come into contact? *Please state details.*

_____
_____
_____

MENTAL HEALTH

Does your child have any mental health issues, behavioural disorders or learning difficulties? *(Provide details)*

_____
_____
_____

Is your child attending counselling? *If yes please provide name of psychologist/specialist.*

_____

ASTHMA

Does your child suffer with asthma? **Yes** ☐ **No** ☐ *(If yes, please continue)*

Name of specialist *(If applicable)* _____ Phone _____

Please indicate severity: **Mild** ☐ **Moderate** ☐ **Severe** ☐

Please state triggers: _____

Preventative used: _____

Reliever used: _____

Has your child ever been hospitalised as a result of an acute attack? **Yes** ☐ **No** ☐

If yes, please provide place and date of last hospitalisation: _____

Age of last asthma episode: _____

ASTHMA ACTION PLAN

Guildford Grammar School Health Centre Staff will follow the guidelines established by Asthma Australia as outlined below when dealing with an acute situation.

Step 1 Sit student upright, remain calm and provide reassurance. Do not leave student alone.

Step 2 Give 4 puffs of a blue reliever *(Airomir, Asmol, Bricanyl or Ventolin)*, one puff at a time via a Spacer device. Ask the student to take 4 breaths from the spacer after each puff.

Step 3 Wait 4 minutes.

Step 4 If there is little or no improvement, repeat steps 2 and 3.
If there is still little or no improvement, call an ambulance immediately (Dial 000).
Continue steps 2 and 3 while waiting for the ambulance.

Additional comments _____

_____

Parent signature: _____ Date: _____

ALLERGIES

Does your child suffer with any allergies? **Yes** ☐ **No** ☐ *(If yes, please complete the following):*

Drug allergy to _____ Reaction: _____

Treatment required _____

Food allergy to _____ Reaction: _____

Treatment required _____

Bee allergy **Mild** ☐ **Moderate** ☐ **Severe** ☐

Treatment required _____

Other allergy to _____ Reaction: _____

Treatment required _____

Has your child been hospitalised as a result of an allergic reaction? **Yes/No** Last hospitalisation date _____

EPIPEN: If your child requires an Epipen (adrenalin) to be administered, you must complete an ASCIA Anaphylaxis Action Plan and contact the Medical Centre Staff on 09377 9211 before your son commences at the school.

MEDICATIONS

Is your child currently taking any medications on a regular basis? **Yes/No** *(If yes, please complete the following)*

Medication 1 Name:_____

Dosage:_____

Condition being treated:_____

Special Instructions:_____

Medication 2 Name:_____

Dosage:_____

Condition being treated:_____

Special Instructions:_____

Medication 3 Name:_____

Dosage:_____

Condition being treated:_____

Special Instructions:_____

(Give details of any additional medications on back cover).

BOARDERS: Please provide all medications with instructions and any prescriptions to the Medical Centre prior to entry to the boarding school.

VISION AND HEARING

Is your child colour blind? Yes ☐ No ☐ Untested ☐

Does your child wear glasses or contact lenses? Yes ☐ No ☐

Does your child wear a hearing aid? Yes ☐ No ☐

DIETARY REQUIREMENTS

Does your child have any special dietary needs? Yes ☐ No ☐ *(If yes, please specify).*

_____

Any additional comments or concerns relating to your child's medical, surgical, mental or emotional history please record below:

_____

_____

_____

_____

_____

The staff at the Medical Centre are available on 9377 9211 for consultation on any medical issues prior to your child commencing at Guildford Grammar Schoool.

PART 2 *FOR BOARDERS ONLY*

Details of a local guardian in Perth must be provided

Guardian's Name: Home Ph:

Address:

Work Ph Mob Email

TO BE COMPLETED BY MEDICAL PRACTITIONER (General Observation and Physical Exam, Boarders only)

Height Weight BP Pulse

Please tick if any abnormality is detected **Please comment or attach documentation** (additional space below)

Ear, Nose and Throat ☐

Respiratory System ☐

Cardio-Vascular System ☐

Central Nervous System ☐

Gastrointestinal System ☐

Musculoskeletal System ☐

Vision ☐

Hearing ☐

Skin ☐

Urogenital System ☐

Urinalysis ☐

Is this student subject to any recurrent complaints or conditions, including enuresis/gastro-intestinal upsets? If so, please specify together with effective past treatment.

Does the student suffer from any disease, injury or illness for which they require any special attention or treatment including chronic fatigue/blood disorders etc? Please provide details?

State of nutrition and development:

Does the student suffer from any mental/emotional disorders ie; separation anxiety/insomnia which staff should be aware of in a boarding environment?

Any additional comments?

Doctor's Signature Date

Practice Name

Doctor's Stamp