Birdwood High School

Student Medical and Health Information 2018

Surname ________________ Given Names __________________ Year _____

The safety, well-being and health of your child are vitally important to us. We make every effort to assist our students, parents and carers in all matters, but can only do so with your cooperation. Please complete the following information.

MEDICAL CONDITIONS

Does this student have any medical condition or health problem that might affect him/her?

(1)	In the classroom	Yes ☐	No ☐
(2)	During Physical Education or Sport	Yes ☐	No ☐
(3)	During Camps, Excursions, Aquatics	Yes ☐	No ☐

If you have answered **YES** to any of the above, please fill in the appropriate places

Condition	YES✓	Likelihood of occurrence	What treatment is required
Severe Allergy (Anaphylaxis) Triggers …………………. (Food/Drug/Insects)			
Mild Allergy Triggers ………………….. (Food/Drug/Insects)			
Asthma			
Other Respiratory			
Diabetes			
Epilepsy / Seizures			
Heart Condition			
Migraine			
Intellectual Disability or Impairment			
Physical Disability or Impairment			
Other - please specify			

Health Plan – Does your student have a current Health Plan? Yes ☐ No ☐
If YES, please provide the school with a copy of the Health plan completed & signed by your doctor.
Health Care plans are available on the school website: **http://www.birdwoodhs.sa.edu.au**

MEDICATION - Is it necessary for this student to take regular medication at school or while on school activities?
Yes ☐ No ☐ **if you have answered YES, please fill in the appropriate places below.**
(All medication that is kept in the first aid room requires a pharmacy label & medication authority form signed by a doctor).

Name of medication(s)	Dose	When to be taken and how often	Possible side-effects

Special Aids

Does this student need to use special aids at school? Yes ☐ No ☐

If you have answered YES, please fill in the appropriate places.

Spectacles - Reading/Distance	☐	Mobility Issues	☐
Contact Lens	☐	Wheelchair - Powered	☐
Hearing Aid	☐	Wheelchair - Hand-propelled	☐

Does the student require access to the lift? Yes ☐ No ☐
Does the student require assistance with personal care? Yes ☐ No ☐
If YES, please specify –

IF YOUR STUDENT HAS ANY MEDICAL CONDITION LISTED ABOVE, PLEASE MAKE SURE THAT THE "RELEVANT MEDICAL CONDITIONS" SECTION ABOVE IS COMPLETE & A CURRENT HEALTH PLAN IS PROVIDED

NAME OF PARENT ______________________________ PHONE ______________________

SIGNATURE OF PARENT/CARER ______________________ DATE ____________

Office Use		Health Care Plan Received & EDSAS Updated		Follow up Letter		2nd Follow up Letter
		Date :		Date:		Date: