BUNDABERG STATE HIGH SCHOOL

Medical Information

Name of Student:____ Year Level: __________

Please indicate any known medical conditions relevant to the student.

Medical Conditions	***Response***	***Additional Comments/Reactions***
Anaphylaxis	Yes / No	**Must provide Medical Action Plan**
Heart / Cardiac	Yes / No	
Blood Pressure	Yes / No	
Diabetic	Yes / No	**Must provide Medical Action Plan**
Respiratory Problems (other than asthma)	Yes / No	
Epilepsy - Seizure	Yes / No	**Must provide Medical Action Plan**
Operations	Yes / No	
Allergies	Yes / No	
Drug Reactions	Yes / No	
Recent Illness	Yes / No	
Mental Health	Yes / No	
Travel / Motion Sickness	Yes / No	
Current Medication	Yes / No	**Must provide Medical Certification**
Other		
Date of most recent tetanus injection		
Other Immunisations received:	Name:	
	Name:	

Asthma		
	Has written permission for student to administer own medication been previously provided to the school?	**If student requires assistance to manage condition. Action Plan must be supplied by a Health Professional**
	I give my permission for the above student to administer their own Asthma medication as required. **(FOR ASTHMA MEDICATION ONLY)**	Signature
Any other Relevant Medical History…		

Medical Insurance Details	
• Does your student have their own Medicare Card?	Yes / No
• What is your student or family's Medicare Number?	
• What is the name of the first person on the family's Medicare Card?	
• Number of Student on Medicare Card?	
• Expiry Date on Medicare Card?	
• Detail any additional Health benefits cover? e.g. Private Hospital, Dental etc.	
• Additional Health Insurance Company and Membership Number?	
• Does the student have a Personal Accident Insurance Cover against Accident/injuries for activities such as travel, sporting competitions etc.	Yes / No

Medical Practitoner	
Name of Family Doctor:	
Address:	
Telephone Number:	

Current Medication Details (if applicable)

Medical Certification MUST BE provided by Health Professional for ALL medication to be administered via First Aid.

Medical Condition	**Name of Medication**	**Times of Administration**

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Medical Action Plan

Please indicate below whether the relevant action plan/s have been attached or if self-administration is suitable for your child. See *Appendix 1*: Checklist for Self –Administration

Diagnosis	Action/Medical Plan		Office Use only	
Asthma	Self-Administration *(Appendix 1 to be completed)* Action Plan from Doctor/Paediatrician required Action Plan from Standard First Aid	☐ ☐ ☐	Medical / Action Plan Received: Renewal Date: ____ / ____ / ____	☐
Anaphylaxis	Self-Administration *(Appendix 1 to be completed)* Action Plan from Doctor/Paediatrician required	☐ ☐	Medical / Action Plan Received: Renewal Date: ____ / ____ / ____	☐
Diabetic Kit	Self-Administration *(Appendix 1 to be completed)* Action Plan from Doctor/Paediatrician/SSRN required	☐ ☐	Medical / Action Plan Received: Renewal Date: ____ / ____ / ____	☐
Epilepsy- Seizure	Action Plan from Doctor/Paediatrician/SSRN Required	☐	Medical / Action Plan Received: Renewal Date: ____ / ____ / ____	☐
Other: e.g. Heart/Cardiac, Mental Health Condition/s			Medical / Action Plan Received: Renewal Date: ____ / ____ / ____	☐

Appendix 1: Checklist for Self-administration

In schools, self-administration may apply to students who are assessed by their parents/carers as capable and approved by the principal as appropriate. Parents/Carer can use this checklist to determine if their child can self-administer their medication (such as Ventolin for asthma, adrenaline for anaphylaxis, and insulin for diabetes). Please note this does not negate the need for staff supervising students with potentially life-threatening health conditions to be trained to administer the medication if your child is unable to do so.

The principal will not approve students who require Ritalin or Dexamphetamine (or other controlled drugs) to keep their medications on their person in order to self-medicate, as these medications must be stored securely in a locked cabinet when not being administered.

Factors For Consideration	***Yes/No***
My student can:	
• confidently, competently and safely administer their own medication following infection control guidelines	
• follow their timetable for administering medication (where it is required at particular times)	
• demonstrate practices of secure storage of medication with their action plan when that medication may be potentially harmful to other students	
• safely dispose of sharps equipment where relevant	
• ensure their medication is in-date.	
Additional information:	

Parent/Carer Signature: ____

Parent/Carer Name: ____
(Please print name)

Date: ______ /______ / _____ Telephone number: ______________________________

Please email this to admin@bundabergshs.eq.edu.au when completed.