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	-Select-	**Must complete Medical Action Plan** *(see over)*
Heart Condition	-Select-	
Blood Pressure	-Select-	
Diabetic	-Select-	**Must complete Medical Action Plan** *(see over)*
Respiratory Problems (other than asthma)	-Select-	
Epilepsy	-Select-	**Must complete Medical Action Plan** *(see over)*
Operations	-Select-	
Allergies	-Select-	
Drug Reactions	-Select-	
Recent Illness	-Select-	
Phobias	-Select-	
Current Medication	-Select-	
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? -Select-	**Must complete Medical Action Plan**
	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?	-Select-
• 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.	-Select-

MEDICAL PRACTITIONER	
Name of Family Doctor:	
Address:	
Telephone Number:	

CURRENT MEDICATION DETAILS (if applicable)		
Medical Condition	**Name of Medication**	**Times of Administration**

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Medical Action Plan

Name of Student: _____ Year Level: _____

Bundaberg State High School reviews the medical condition of all students at the beginning of each year. **It is the parent/carers responsibility to pass on this important information** to enable us to provide appropriate first aid and treatment for students.

Each year, School Staff require a signed Action Plan for **all** students with a diagnosis of Anaphylaxis and some students who have Asthma (see additional details below). These plans are obtained and signed by the treating medical practitioner or your General Practitioner.

An Asthma Action Plan is required if:

- the student requires staff assistance with medication
- the student's Emergency Medication is different to standard Asthma First Aid.

Student's with Diabetes, Epilepsy or other health conditions where emergency assistance or a specialized health procedure is required at school also require a Health Plan or Emergency plan for school. These can be developed with the assistance of the State Schools Registered Nurse (by referral) or your treating medical team.

Please provide the **current written Action Plan and/or Emergency Health Plan** to the school with your enrolment. You can drop this into Bundaberg State High School First Aid office, located in A Block office along with your student's medication (if applicable) or scan and email to principal@bundabergshs.eq.edu.au

Diagnosis	Student Managed	Action/Medical Plan	Office Use only
Asthma	Yes	Self-Administration ☐ Action Plan from Doctor Required ☐ Action Plan from Standard First Aid ☐	Medical / Action Plan Received: ☐ Renewal Date: ____ / ____ / ____
Anaphylaxis	Yes	Self-Administration ☐ Action / Medical Plan Required From Medical Practitioner ☐	Medical / Action Plan Received: ☐ Renewal Date: ____ / ____ / ____
Diabetic Kit	Yes	Self-Administration ☐ Action / Medical Plan Required From Medical Practitioner ☐	Medical / Action Plan Received: ☐ Renewal Date: ____ / ____ / ____
Epilepsy	Yes	Self-Administration ☐ Action / Medical Plan Required From Medical Practitioner ☐	Medical / Action Plan Received: ☐ Renewal Date: ____ / ____ / ____
Other:			Medical / Action Plan Received: ☐ Renewal Date: ____ / ____ / ____

Parent/Carer Signature: _____

Parent/Carer Name: _____
(Please print name)

Date: _____ /_____ / _____ Telephone number: _____