NEW LIGHT VISION CHRISTIAN INSTITUTE

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OFFICE USE ONLY
Date Received: _____
Received by: _____
_____
Student Folders'#: _____
Student' ID's: _____
Date Entered on SR: _____
Entered on SI by:_____

FORM 1 – STUDENT HEALTH CARE SUMMARY

SECTION A

School: **NEW LIGHT VISION CHRISTIAN INSTITUTE**

Year Group: **1□ 2□ 3□ 4□ 5□ 6□ 7□**

Student's Name: _____

Date of Birth: _____

Address: _____

Gender: male□ female□

FAMILY CONTACT DETAIL **MEDICAL DETAILS**

Excursion/program name: Teacher to fill this in
Date(s): Teacher to fill this in

Student's full name:

Student's address:

Postcode:

Date of birth: Year level:

Parent/guardian's full name:
Emergency telephone numbers: *After hours* *Business hours*

Name of person to contact in an emergency (if different from the parent/guardian):
_____

Emergency telephone numbers: *After hours* *Business hours*

Name of family doctor:_____
Address of family doctor:

Phone number:

Medicare number:

Medical/hospital insurance fund: Member number:

Ambulance subscriber? ☐ Yes ☐ No If yes, ambulance number:

Is this the first time your child has been away from home? ☐ Yes ☐ No

Please tick if your child is living with any of the following health conditions:

☐ Asthma (if ticked complete Asthma Management Plan)

☐ Anaphylaxis (if ticked review and update the Individual Management Plan for the camp or excursion)

☐ Bed wetting ☐ Blackouts ☐ Diabetes ☐ Dizzy spells ☐ Migraine

☐ Heart condition ☐ Sleepwalking ☐ Travel sickness ☐ Seizure of any type

*Haematological diseases *Diseases of the nervous system *Diseases of the muscles/bones *Other diseases

☐ Other: _____

_____

Allergies
Please tick if your child is allergic to any of the following:

☐ Penicillin ☐ Other Drugs: _____

☐ Foods: _____

☐ Other allergies: _____

What special care is recommended for these allergies? _____

_____

Year of last tetanus immunisation: _____
(Tetanus immunisation is normally given at five years of age (as Triple Antigen or CDT) and at fifteen years of age (as ADT))

Medication
Is your child taking any medicine(s)? ☐ Yes ☐ No
If yes, provide the name of medication, dose and describe when and how it is to be taken.

_____

_____

All medication must be given to the teacher-in-charge. All containers must be labelled with your child's name, the dose to be taken as well as when and how it should be taken. The medications will be kept by the staff and distributed as required. Inform the teacher-in-charge if it is necessary or appropriate for your child to carry their medication (for example, asthma puffers or insulin for diabetes). A child can only carry medication with the knowledge and approval of both the teacher-in-charge and yourself.

Medical consent
Where the teacher-in-charge of the excursion is unable to contact me, or it is otherwise impracticable to contact me, I authorise the teacher-in-charge to:

· Consent to my child receiving any medical or surgical attention deemed necessary by a medical practitioner.
· Administer such first-aid as the teacher-in-charge judges to be reasonably necessary.

Note: You should receive detailed information about the excursion/program prior to your child's participation and a Parent Consent form. If you have further questions, contact the school before the program starts.
Does the student have any medicine with him/her (give details)?
……
……
How will the medicine be managed?
……
……
……
……

Concerns:
……
……
……
……

Current medication

Name of medicine	Dose	Amount	Frequency

Please complete the vaccination record below:

VACCINE	DATE					
Diphtheria*						
Tetanus*						
Polio*						
MMR*						
Hepatitis B**						
Varicella ***						
HPV** 11-14 year old girls						
Meningococcal C						

* Required vaccinations for school admission
** Recommended vaccinations
***Has the child had chicken pox? If no, consider vaccination

Signature of parent/guardian (named above)_____
Date:

The Department of Education and NELVCI requires this consent to be signed for all students who attend the NEW LIGHT VISION CHRISTIAN INSTITUTE.