



OFFICE USE ONLY

Date Received: _____

Date Entered: _____

Student Name:

Student Code:

Year Level:

THE LAKES COLLEGE MEDICAL DETAILS FORM

In the interests of your child's welfare we ask that you complete this form and return to the College Health Centre prior to the commencement of the school year. The information provided by you in this document will be treated as strictly confidential and will only be shared with relevant staff when necessary.

The College suggests that you retain a copy of this form for your records. Please fill out this form as completely as possible as this information will assist us greatly in the event of a medical emergency. Should there be any changes to your child's details, please arrange for the College to update your child's information as soon as possible, alternatively, medical details can be updated through Parent Lounge.

Please note: If you require College staff to administer non-prescription or prescription medication then the medication must have a pharmacy label including your child's name and dosage affixed to the packaging. Request for administering of any medication must be accompanied by an Administration of Medication form that is available from the Health Centre.

TLC Health Centre
healthcentre@thelakes.qld.edu.au

PO Box 888, North Lakes Qld 4509
Phone: 07 3491 5555 Fax: 07 3491 5599

STUDENT INFORMATION

Section 1 – Student details (a separate form must be completed for each child)

Student Surname: _____ First Name: _____
Year Level: _____ Date of Birth: _____
Medicare Number: _____ Card Reference Number: _____ Expiry Date: ____ / ____
Private Health Insurance: Yes No
Private Health Number: _____ Fund Name: _____

EMERGENCY CONTACT other than parent

Section 2 – An emergency contact person is required for all students enrolled at The Lakes College. Please note that the Parent/Guardian will always be contacted in the first instance.

Full Name: _____
Relationship to child: _____
Address: _____
Suburb: _____ Postcode: _____
Mobile No: _____ Home No: _____

IMMUNISATIONS

Section 3 – please select Yes or No

My child's immunisations are up to date:

Please select: Yes No

GENERAL MEDICAL CONDITIONS

Section 4 – This information will be used for camps, excursions and other College activities

MEDICAL CONDITION	YES/NO	Severe Yes/No	DETAILS
Allergies (including anaphylaxis)	Yes	Yes	Details:
	No	No	
	Date of last occurrence:		Medication (if applicable): Medication supplied to Health Centre: Yes No Anaphylaxis Action Plan supplied to Health Centre (if applicable): Yes
Asthma and/or Respiratory problems	Yes	Yes	Details:
	No	No	
	Date of last occurrence:		Medication (if applicable): Medication supplied to Health Centre: Yes No Asthma Management Plan supplied to Health Centre (please see Section 7 if no): Yes
Diabetes	Yes	Yes	Details:
	No	No	
	Date of last occurrence:		Medication (if applicable): Medication supplied to Health Centre: Yes No
Epilepsy	Yes	Yes	Details:
	No	No	
	Date of last occurrence:		Medication (if applicable): Medication supplied to Health Centre: Yes No
Dietary Requirements	Yes	Yes	Details:
	No	No	
	Date of last occurrence:		Medication (if applicable): Medication supplied to Health Centre: Yes No
Other Medical Conditions <small>(eg. visual/hearing/ skeletal/psychological/ migraine/heart conditions)</small>	Yes	Yes	Details:
	No	No	
	Date of last occurrence:		Medication (if applicable): Medication supplied to Health Centre: Yes No

If you require more space please see Section 8 on the back page

MEDICATION

Section 5 – In an emergency situation, the Registered Nurse/authorised person may administer certain medications

The Registered Nurse/authorised person may administer prescribed/over-the-counter medication to your child:

Please select: Yes / No

If Yes, please tick which of the following medications you approve:

- Paracetamol
- Ibuprofen
- Antihistamine

Parent/Guardian Name: _____ Signature: _____

SIGNATURES REQUIRED

Section 6 – Signatures required please

In any medical emergency, every effort will be made by the College to communicate immediately with parents or their nominated emergency contact, as a matter of top priority. However, where emergency treatment is required, please provide your consent for the College to act on your behalf:

I authorise The Lakes College staff to obtain medical attention for my child at staff discretion in the event of illness/injury.

Parent/Guardian Name: _____ Signature: _____

I declare that the information provided on this form is complete and correct as at the date of signing. Should any information change regarding my child's medical requirement during the course of their enrolment at The Lakes College, I will immediately notify the College Health Centre.

Parent/Guardian Name: _____

Signature: _____ Date: _____

IMPORTANT INFORMATION please read

Section 7 – Should you have information from your child’s medical practitioner and you wish for us to include this in your child’s confidential file, please organise copies for the College or alternatively we are happy to copy information for you. (Information will only be shared with relevant staff)

ASTHMA AUSTRALIA FIRST AID PLAN

In the absence of an Asthma Management Plan, staff will follow the Asthma Australia First Aid Plan:

In the event of an Asthma episode and the absence of a management plan, the staff at The Lakes College will follow the Asthma Australia First Aid Plan, as outlined below:

1. Sit the student upright. Be calm and reassuring. Do not leave the student alone.
2. Give 4 puffs of blue reliever puffer medication with spacer – Shake puffer – Administer 1 puff into spacer – Take 4 breaths from spacer. Repeat until 4 puffs have been taken. **Remember: Shake, 1 puff, 4 breaths**
3. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per Step 2.
4. If there is no improvement, call an ambulance 000 immediately. Keep giving 4 puffs every 4 minutes until emergency services arrive. Commence CPR if casualty becomes unconscious and unresponsive and not breathing/not breathing normally.

- In the event of an asthma attack at school, I agree to my child receiving the treatment described above.
- I authorise College staff to assist my child with taking asthma medication should they require help.
- I will notify the College in writing if there are any changes to these instructions.
- Please notify me if my child regularly has asthma symptoms at school.
- Please notify me if my child has received asthma first aid.
- I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent/Guardian Signature _____

Date: _____

*Should you require further information in relation to the
Asthma Foundation Emergency First Aid plan, please contact:
Asthma Australia on 1800 645 130 or web address www.asthmafoundation.org.au*

