LHD CONFIDENTIAL MEDICAL FORM

Student's Name:_____

MEDICAL DETAILS

Doctor's Name: _____

Doctor's Phone No.: _____

Ambulance Subscription: Yes ☐ No ☐

Membership No.: _____ Expiry Date: _____/_____

Medicare No.: _____/_____/_____ Ref. No.: __ Expiry Date: _____/_____

MEDICAL HISTORY

1. Has your child been medically diagnosed with:

Anaphylaxis	☐	Please specify: _____
Asthma	☐	
Anxiety Disorder	☐	
Allergies	☐	Please specify: _____
Epilepsy	☐	
Diabetes	☐	
Heart Condition	☐	
Migraines	☐	
Sight Disorder	☐	Please specify: _____
Hearing Disorder	☐	Please specify: _____
Bleeding Disorder	☐	Please specify: _____
Phobia	☐	Please specify: _____
Other	☐	Please specify: _____

If you have ticked any of the boxes above please provide a Management Plan signed by your doctor.

2. Does your child take any medication for the condition stated above: Yes ☐ No ☐

EpiPen	☐	**An Anaphylaxis Management Plan must be provided**
Nebuliser	☐	**An Asthma Management Plan must be provided**
Other	☐	Please specify: _____

3. Does your child have a diagnosed disability? Yes ☐ No ☐

If yes, please specify: _____

4. Has your child had a serious injury in the last 12 months? Yes ☐ No ☐

If yes, please specify: _____

DECLARATION/AUTHORISATION

- I/We declare that the information which I/We have provided on this form is complete and correct and that I/We will notify LHD if any changes occur.
- I/We authorise the teacher or any employee of LHD who is with my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary.
- I/We give permission for LHD staff to pass this information to a third party (i.e. Ambulance Officer, Doctor, Hospital) to facilitate the medical treatment of my child.
- I/We give permission for this form to be retained noting that I can access it at any time.

Parent/Legal Guardian Name: _____ Signature: _____ Date: _____

Parent/Legal Guardian Name: _____ Signature: _____ Date: _____