

The information collected on this form is to assist staff and medical professionals in case of the requirement for first aid and or in the event of an accident or emergency either at school or off site on excursions. Information is personal, is stored on site and a copy of each student's form is taken on any excursion. Information is used in accordance with the regulations of the *Privacy Act 1998(Cwth)*. Please note: conditions noted with an asterix (\*) below require an Emergency Treatment Plan.  
**In the absence of a plan only standard first aid should be administered.**

**Personal Details**

Student's Name:				Date of Birth:		Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
School:		School Year:		Camp/Excursion:			
Parent/Carer:							
Address:							
Business Hours:		After Hours:		Mobile:			
Emergency Contacts 1:					Telephone No:		
Emergency Contacts 2:					Telephone No:		
Name of Doctor:					Telephone No:		
Medicare No:		Private Health Fund:		Membership No			
Ambulance Fund: NOTE: Parents are responsible for ambulance costs outside the ACT.							

Please tick if your child suffers any of the following:

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> allergies                    | <input type="checkbox"/> blood pressure | <input type="checkbox"/> epilepsy*         | <input type="checkbox"/> hay fever       | <input type="checkbox"/> nose bleeds            |
| <input type="checkbox"/> anaphylaxis*                 | <input type="checkbox"/> diabetes*      | <input type="checkbox"/> fainting          | <input type="checkbox"/> headaches       | <input type="checkbox"/> reaction to drugs      |
| <input type="checkbox"/> asthma*                      | <input type="checkbox"/> eczema         | <input type="checkbox"/> fits or blackouts | <input type="checkbox"/> heart condition | <input type="checkbox"/> sight/hearing problems |
| <input type="checkbox"/> other (please specify) _____ |   |  |  | <input type="checkbox"/> sun screen sensitivity |

**\*Emergency treatment plan required from your Doctor. Templates are available at or by contacting your school.**

**Describe what happens for any of the conditions ticked above**

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Date of last tetanus injection:	
Is the student presently taking any medication? parents must give written permission and directions for the administration of any medication taken during school hours or after hours school activities):	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you aware of any physical or psychological limitations of your child? Please give details.	
Is there any other information which you believe may help us to provide the best possible care?	

**Consent to medical attention.** In the case of my child requiring medical treatment or in the case of a medical emergency; I consent to the school providing first aid or treatment as outlined in an emergency treatment plan. I authorise the school, where it is impracticable to communicate with me, to arrange for him/her to receive such medical or surgical treatment as may be deemed necessary. I undertake to pay any costs which may be incurred for the medical treatment, ambulance transport and drugs.

Signed.....

Date.....

Office Use Student central ID: _____ Entered into MAZE: <input type="checkbox"/> Date: _____
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