MEDICAL INFORMATION

Please complete details according to student's Birth Certificate.

1) CAMP/EXCURSION DETAILS

Name of Camp/Travel Program/Excursion

Destination

Date

2) STUDENT DETAILS

First Name

Nickname

Surname

Date of Birth

/ /

Mobile Telephone Number

Home Telephone Number

Email Address

Address

Suburb

Postcode

Male ❑ Female ❑

3) PARENT/LEGAL GUARDIAN DETAILS

Main Parent/Guardian

First Name

Surname

Relationship to Student

Mobile Telephone Number

Daytime Telephone Number

Email Address

Address : As above ❑

Second Parent/Guardian Details

First Name

Surname

Relationship to Student

I request a copy of correspondence: Yes❑ No❑

Mobile Telephone Number

Daytime Telephone Number

Email Address

Address

4) MEDICAL INFORMATION

Medicare No

Private Health Insurance ❑Yes ❑No
Membership No:

Ambulance subscriber ❑Yes ❑No ❑Health Care Card/Pension Card

Travel Insurance (if applicable) ❑Yes ❑No Policy No:

Has the student ever suffered from any of the following?

Asthma
Yes❑ No❑
Allergies
Yes❑ No❑
Epilepsy
Yes❑ No❑
Diabetes
Yes❑ No❑
Heart Condition
Yes❑ No❑

Recurring Migraines
Yes❑ No❑
Joint Problems
Yes❑ No❑
Back Trouble
Yes❑ No❑
Psychiatric/Psychological illness
Yes❑ No❑
Eating Disorder
Yes❑ No❑

Depression
Yes❑ No❑
Behavioural Issues
Yes❑ No❑
Disability
Yes❑ No❑
Other:

If any of the above are ticked, please attach a Medical Management Plan.

Does the student

Have objections to any treatment, eg, blood transfusion? Yes❑ No❑ Details

Take medication for a condition not mentioned? Yes❑ No❑ Details

Have specific dietary requirements eg vegetarian/kosher? Yes❑ No❑ Details

Please write on a separate sheet if necessary, any other matters, ailments, medical conditions or circumstances that are not covered by the above questions which may be relevant in helping ensure the safety of the student. In order to validate the insurance of the student during the travel, we will have to pass the information you provide in this section to the insurer, medical advisors and the Leadership team and travel coordinator. Please sign below to agree to these details being used in this way. We cannot process the application without such authorisation. We will not use the information you provide other than for the reasons set out above and shall not forward the information to any third parties without first obtaining your consent.

5) IMMUNISATION DETAILS:

Has the student been immunised against:

Tetanus	Whooping Cough	Hepatitis A
Yes❑ No❑	Yes❑ No❑	Yes❑ No❑
Typhoid	Polio	Hepatitis B
Yes❑ No❑	Yes❑ No❑	Yes❑ No❑
Diphtheria	Measles, Mumps, Rubella	Other:
Yes❑ No❑	Yes❑ No❑	

If necessary, an immunisation record, including dates of injections may be requested.

6) Student Declaration and Parent/Guardian Consent

A. I understand the nature of the program and consent to the student taking part in the camp activities.
B. I confirm that to the best of my knowledge, this form has been completed accurately and I agree to inform Mornington Secondary College immediately of any changes.
C. I have read, understood and agree to be bound by the travel conditions and specification that all cancellations, alterations and refunds will be in accordance with the booking conditions, travel insurance (if applicable) and/or College policies.
D. I acknowledge that participation in the program may be subject to medical clearance, if the College has any queries regarding the student's medical condition.
E. I authorise the teacher in charge of the camp program to sign any consent forms required by medical authorities present before any medical treatment may be given to the student.
F. I agree to the student receiving medication, emergency dental, medical or surgical treatment whilst on the camp program/activity, including, but not limited to anaesthetic and/or blood transfusion as considered necessary by the medical authorities present.
G. I agree to the student taking part in the activities detailed in the itinerary and understand that I have the opportunity to withdraw consent in writing

STUDENT MEDICAL MANAGEMENT FORM

(Diabetes, Anaphylaxis, Asthma, Epilepsy)

The following confidential information is required to assist in the management of a child's medical condition if such help is needed. Please complete and attach to the Medical Consent form. When completing this form, please seek the advice of your student's doctor if necessary.

CONDITION:❒ Asthma ❒ Anaphylaxis ❒ Epilepsy ❒ Diabetes

1. USUAL SIGNS OF CONDITION. PLEASE TICK AS APPLICABLE.

□ Wheezing	□ Chest tightness	□ Coughing	□ Difficulty breathing
□ Difficulty speaking	□ Hives	□ Rash	□ Blueness of lips
□ Tingling of lips	□ Difficulty speaking	□ Stiffing of body	□ Jerking
□ Loss of consciousness	□ Other:		

2. USUAL MAINTENANCE REGIME OR MEDICAL PROGRAM

Name of Medication..

Method: ❒Puffer & spacer ❒ Tubohaler ❒ EpiPen ❒Other ....

When and how much? ....

Does the child require assistance to take their medication: ❒Yes ❒No

3. SIGNS OF WORSENING CONDITION

Wheezing	Chest tightness	Coughing	Difficulty breather
Difficulty speaking	Hives	Rash	Blueness of lips
Tingling of lips	Difficulty speaking	Stiffening of body	Jerking
Loss of consciousness	Other:		

Medication and treatment to be used during worsening condition ....

....

4. MEDICATION AND TREATMENT TO BE USED DURING CRISIS SITUATIONS

....

....

....

5. LIST ANY KNOW TRIGGER FACTOR (S)

....

Has the student been admitted to hospital due to this condition in the past 12 months? ❒Yes ❒No

Has the student been on oral cortisone for asthma within the past 12 months? (eg Pednisolone, Cortisone, Betamethasone, etc.) ❒Yes ❒No

Has the student ever suffered sudden severe asthma attacks requiring hospitalisation? ❒Yes ❒No

Has the student ever had an anaphylactic reaction? ❒Yes ❒No When?...

Signature of student

	Date: / /

Signature of Parent/Guardian

	Date: / /