Westbourne Grammar School
ABN 60 004 363 035

medical data

Family Name of student | Given Names

Current Year level | Date

EMERGENCY CONTACT (OTHER THAN PARENTS)

1st Contact Name | Phone

Address

Relation to student (if any)

2nd Contact Name | Phone

Address

Relation to student (if any)

Doctor | Phone

Dentist | Phone

Ambulance Fund Membership Number

Medicare Number

Name of Private Health Insurance

Private Health Insurance Membership Number

If student attending any specialists, please note:

Name | Phone

Type of specialist(s)

MEDICAL TREATMENT CONSENT

In the event of my daughter/son (given names, family name)_____ requiring medical attention and treatment whilst travelling to and from school, whilst at school, on school camp or outdoor activity, I authorise the School to obtain all necessary assistance or hospital accommodation, with expenses incurred to be met by me. I further authorise the use of anaesthetic by a qualified anaesthetist if in his/her judgement this is necessary. I understand that every effort will be made by the School to contact the parent or guardian in the event of such illness or accident.

Additional medication or action to be taken in an emergency (eg asthma, allergies, cardiac etc.)

Parent/Guardian Signature | **Date**

Westbourne Grammar School is bound by the National Privacy Principles contained in the Commonwealth Privacy Act. To obtain a copy of the School's Privacy Policy contact the Director of Admissions and Marketing, Ms Ellie Hogan on 9731 9412 or visit our website on www.westbournegrammar.com
Westbourne Grammar School (00355F) – Cricos Course Code 016541F

IMPAIRMENTS

Defect in vision	YES/NO	**Type of impairment**	
Glasses worn	YES/NO	Contact lenses worn	YES/NO
Defect in hearing	YES/NO	**Type of impairment**	
Type of aid used			
Any other physical disability			

SEVERE ALLERGIES

Please complete the following, if applicable.

1. My child has an allergy to:

- ☐ Insect bite *(please specify)*
- ☐ Drug *(please specify)*
- ☐ Food:
  - Peanuts YES/NO
  - Other nuts YES/NO
  - Fish YES/NO
  - Shellfish YES/NO
  - Other *(please specify)*
- ☐ Latex *(please specify)*
- ☐ Other *(please specify)*

2. My child has been hospitalised with a severe allergic reaction YES/NO

3. My child has been prescribed an Epi-Pen YES/NO

4. If immediate medication is required in reference to allergies, please state:

RECORD OF HEALTH RELATED CONDITIONS

☐ Asthma	☐ Drug Reactions	☐ Blood Disorders
☐ Allergy	☐ Diabetes	☐ Glandular Fever *(specify date)*
☐ Respiratory problems	☐ Migraines	☐ Fits, epilepsy, blackouts, dizzy spells, vertigo
☐ Phobias	☐ Travel sickness	☐ Joint, knee or back problems
☐ Sleep walking	☐ Heart/Blood Pressure problems *(please note fully)*	

Please provide additional information including **any medication** used for items above that have been marked in the affirmative.

If immediate medication is required in reference to allergies, please state:

Recent illnesses (other than those above) with date			
Recent fractures or bone disorders			
Recent operations			
Special dietary requirements			
Current medical or dental treatment			
Current tetanus immunisation status		Date of last Hep.B injection	
Pre-school vaccinations	YES/NO		
If "NO" please give a reason			