Monte Sant’ Angelo Mercy College
STUDENT MEDICAL and EMERGENCY CONTACT FORM

For students commencing at Monte in 2017

STUDENT’S FULL NAME: ____________________________________________________________

MEDICAL DETAILS

Doctor’s Name: ___________________________ Phone No. __________________________

Medicare No: ______________ Expiry: ______________ Place on Card ______________

Health Fund: ___________________________ Membership No. ______________

MEDICAL HISTORY

Has your child been diagnosed with any of the following conditions:
☐ asthma ☐ ADHD ☐ diabetes ☐ chronic fatigue ☐ migraine ☐ Mental Wellbeing Issues

Any others? Please list: ___________________________________________________________

Has your child suffered from any of the following infectious diseases:
☐ measles ☐ mumps ☐ hepatitis ☐ chicken pox ☐ glandular fever

Any others: Please list: ___________________________________________________________

ALLERGY INFORMATION

Does your child suffer from any food allergies?

If yes, please list: _______________________________________________________________

Does your child suffer from any other known allergies?

If yes, please list: _______________________________________________________________

Has your child been hospitalised with a severe allergic reaction? YES / NO

Has your child been prescribed with an EpiPen? YES / NO

If so, please provide an action management plan.

SWIMMING ABILITY

Please indicate your child’s level of ability to swim 100m unassisted. Please circle:

Strongly / Comfortably / With a struggle / Not at all
ASTHMA INFORMATION

Does your child suffer Asthma? YES / NO
If yes, complete the following:

1. Has your child been hospitalised for Asthma in the last 2 years? YES / NO
2. Has your child been treated with oral Cortisone in the past year? YES / NO
3. Does your child have an Asthma Plan? YES / NO
4. Current Reliever is: __________________________________________
5. Current Preventer is: __________________________________________
6. Other medication taken for Asthma: __________________________________________

If your child has one, please provide a copy of her Asthma Management Plan.

IMMUNISATIONS:

Please indicate which immunisations your child has received and the most recent date administered:

<table>
<thead>
<tr>
<th>Immunisation</th>
<th>YES / NO</th>
<th>Most Recent Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>DTPa (Adult Diptheria/Tetanus/Pertusis)</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Gardasil (Human Papillomavirus)</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Hep B</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Measles/Mumps/Rubella</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td>YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

PERMISSION TO GIVE:

1. Paracetamol: □ Yes □ No
2. Authorised Medications:

Please list below any prescription medications that your child takes regularly, the dosage and which condition it is for:

1. __________________________________________
2. __________________________________________
3. __________________________________________
MISCELLANEOUS INFORMATION:
Is there any other information (medical or non-medical) of which the School needs to be aware?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Emergency Contact Information
Please provide below contact details for TWO people OTHER THAN PARENT/CARER to be used as emergency contacts in the event that the College cannot contact parents/ carers in an emergency situation.

In the event of an emergency, it is the College's policy to attempt to contact parents/ cares on all numbers provided BEFORE contacting emergency contacts

Name_______________________________________________________________________________
Relationship__________________________________________________________________________
Address_______________________________________________________________________________
Phone (home) ______________________________ Mobile __________________________
Email _______________________________________________________________________________

Name_______________________________________________________________________________
Relationship__________________________________________________________________________
Address_______________________________________________________________________________
Phone (home) ______________________________ Mobile __________________________
Email _______________________________________________________________________________

CONFIRMATION & AGREEMENT – Must be completed
Please sign and date the form below. By signing below you agree that all information contained in this Medical and Emergency Contacts Form is accurate and up-to-date and that you have read Monte's Privacy Policy.

Signed: _____________________________________________ Parent/Guardian
Name: _____________________________________________ Date: ___ / ___ / ______
Please print name clearly