Student Medical and Dietary Information

Email your completed form to jdola23@eq.edu.au

PLEASE ENSURE THAT YOU COMPLETE THE MEDICAL INFORMATION FORM ACCURATELY

Full Name		Date of Birth	

The school collected medical information about your child at registration/enrolment. This information is stored electronically in OneSchool. Please give full details of any new or updated medical information which may affect your child's full participation in the excursion described in the form.

You may also wish to update/provide the following optional information:

Name of child/student's medical practitioner:

Telephone No.:

Medicare No.:

Private Health Insurance Company (if applicable):

Membership No.:

***Students that are independent, mature-age or over 18 years of age may provide their own consent and be responsible for all related costs.**

Swimming Ability: ◉ Unable to swim ○ limited ○ moderate ○ confident

Has your child/ward had a Tetanus booster in the last 12 months? Yes No

Does your child/ward have any of the following? Please give full details including severity, medication, date of last incident, operation etc.

Condition	Response	Details (including severity etc.)	Condition	Response	Details (including severity etc.)
Heart Condition	◉ Yes ○ No		Asthma	◉ Yes ○ No	
Epilepsy	◉ Yes ○ No		Respiratory Condition	◉ Yes ○ No	
Diabetes	◉ Yes ○ No		Blood Pressure	◉ Yes ○ No	
Bed Wetting	◉ Yes ○ No		Disability	◉ Yes ○ No	
Sleepwalking	◉ Yes ○ No		Phobias	◉ Yes ○ No	
Travel Sickness	◉ Yes ○ No		Other?	◉ Yes ○ No	

Additional Information

<table>
<tr><td colspan="4">Does your child have any allergies? Please give full details including an Action Plan outlining severity, date of last reaction/incident, date of formal diagnosis etc. Parents – please ensure your child is fully aware of any known allergies prior to attending camp as your response is deemed final and no variance will be permitted.</td></tr>
<tr><td>Allergy / Intolerance to</td><td>Response</td><td colspan="2">Details</td></tr>
<tr><td rowspan="2">Anaphylaxis</td><td rowspan="2">Yes No</td><td>Epi-Pen Carried:
Yes No</td><td>Action Plan Completed:
Yes No</td><td>Date of Last Reaction:</td></tr>
<tr><td colspan="3">Reaction Caused by:</td></tr>
<tr><td>Drugs</td><td>Yes No</td><td colspan="3">Details</td></tr>
<tr><td>Creams / Lotions</td><td>Yes No</td><td colspan="3"></td></tr>
<tr><td>Foods</td><td>Yes No</td><td colspan="3"></td></tr>
<tr><td>Other?</td><td>Yes No</td><td colspan="3"></td></tr>
<tr><td colspan="4">Dietary Requirements: In addition to food allergies, if your child has any other dietary requirements or restrictions, please mention below. i.e., vegan, no pork</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Medication: If your child requires medication (including creams, lotions, Panadol etc.) of any description please complete second part of this form ‘Consent to administer medication’. This is mandatory, regardless if it is self-administered or a staff member is required to administer. The form must be completed and returned to organising teacher prior to camp.</td></tr>
</table>

Medical Requirements

Please ensure that you complete and return the additional medical and dietary information section of the consent form. This collects other important medical information necessary for camp that is not necessarily collected at enrolment.

- If your child requires any medication while on camp, please send this in a labelled Ziplock bag.
- Students are to give their medical to the designated medication officer *before* we depart for camp.
- Dietary requirements will be forwarded to PGL Kindilan Adventure Camp.

Email your completed form to jdola23@eq.edu.au

Consent to administer medication

PLEASE NOTE:

For medication to be administered at school or during school-related activities, there must be medical authorisation for the student to have that medication, and the medication must be in its original container with intact packaging.

Examples of medical authorisation include:

- a pharmacy label with both the student's and doctor's name on it;
- a signed letter from a doctor;
- a medication order from a dentist;
- an Action Plan signed by a doctor or nurse practitioner.

See below for examples of health conditions, medications and associated documentation:

Health condition/ reason for medication	**Example of medication**	**Documentation completed by doctor or other prescribing health practitioner**
Asthma	Asthma puffer	*Asthma action plan*
Anaphylaxis	EpiPen	ASCIA *Anaphylaxis Action Plan*
Diabetes	Insulin injection, insulin pump	Department of Education *Medication order to administer 'as-needed' medication at school* or medication order or other written instructions from prescribing health practitioner and *diabetes management plan*
Other types of emergency medication e.g. for seizures	Midazolam	Department of Education *Medication order to administer 'as-needed' medication at school*
Medication required 'as needed' for minor or non-emergency symptoms	Ointment for skin allergies, antihistamines	Department of Education *Medication order to administer 'as-needed' medication at school*
Changes to dosage (e.g. from ½ to 1 tablet)	Ritalin	Written instructions from prescribing health practitioner (e.g. doctor)

1. To request that the school administer medication to a student

1) Complete Section A (page 2).
2) Provide the school with the medication in the original container with intact packaging.
3) Provide the written medical authorisation (e.g. completed pharmacy label, medication order, action plan) completed and signed by the prescribing health practitioner.
4) Make an appointment with the principal/delegate if:
   - the student requires medication as an emergency response;
   - you would like the student to self-administer their medication;
   - the student has complex health support needs or requires other support strategies; or
   - you have any concerns about the student's health which may affect their schooling.

2. To request a student self-administer their medication

1) Complete Section A (page 2) and Section B (page 3).

Consent to administer medication

Privacy Statement
The Department of Education (DoE) is collecting this personal information for the purpose of enabling school staff to administer medication to the nominated student, or to support a student to self-administer their medication while at school or during school-related activities. This information will only be accessed by authorised departmental employees. In accordance with section 426 of the *Education (General Provisions) Act 2006* (regarding student's personal information) and the *Information Privacy Act 2009* (parent/carer's personal information) this information will not be disclosed to any other person or body unless DoE has been given permission or is required or authorised by law to disclose the information.

Section A: *Complete the details below:*

NOTE: This form only collects information for one (1) medication. If more than one medication is required, please complete a separate form for each medication.

Student name		**Date of birth**	
Parent/carer name		**Phone number**	

- I consent to the following medication being administered (as per the instructions on the pharmacy label and/or any additional written instructions) to the student named above during school or school-related activities.
- I authorise school staff to contact the prescribing health practitioner or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication to this student.

Name of medication	

I confirm that the medication provided to the school (as listed above):

☐ is medically authorised *(e.g. has been prescribed by a doctor, dentist, optometrist or nurse practitioner)*
☐ is in the original dispensed container with intact packaging
☐ has the student's and doctor's names on the pharmacy label *(if there is no other written evidence of medical authorisation)*
☐ is current/in-date *(*The expiry date of the medication is _ _ / _ _ / _ _ _ _*).*

The medication is required:		If **Yes** to any questions, complete the following:
(a) routinely (e.g. 11am every day)	☐ **No** ☐ **Yes⇨**	Administer at _ _: _ _ am/pm on the following days: *(circle the day/s required)* Monday Tuesday Wednesday Thursday Friday
(b) for a short time only (e.g. only for 2 weeks)	☐ **No** ☐ **Yes⇨**	Start date: _ _ /_ _ / _ _ _ _ End date: _ _ /_ _ / _ _ _ _
(c) to manage a health condition by following a current action plan or health plan	☐ **No** ☐ **Yes⇨**	Is the medication for: ☐ asthma ☐ anaphylaxis ☐ diabetes ☐ epilepsy ☐ cystic fibrosis ☐ other *(describe)*
(d) 'as needed' to treat minor or non-emergency symptoms	☐ **No** ☐ **Yes⇨**	☐ I understand that before the school administers this medication, if they are not aware of when this medication was most recently given to this student, I will be contacted to provide this information.

Has this student previously shown any side effects after taking this medication?	**Yes** ☐ **No** ☐

If **Yes**, describe: _____

Parent/carer/student signature		**Date**	

If the student is to self-administer this medication, also complete **Section B**
NOTE: Controlled drugs cannot be self-administered.

Section B*: Details for student self-administration of medication:*			
In all cases and at any time, the principal/delegate may disallow student self-administration for health and/or safety reasons.			
Student name		**Date of birth**	

- I confirm that the student is confident, competent and can safely administer the right dose of their own medication at the right times.
- I confirm that the student can store their medication securely.
- I authorise school staff to contact the prescribing health practitioner, health team or pharmacist (as listed on the medication's pharmacy label or in other relevant medical authorisation) for the purpose of seeking specific advice or clarification on the administration of this medication by this student.

Health condition	
☐ Asthma - secondary school students only	☐ I approve for the student to self-administer their asthma medication. **NOTE:** The school will need a copy of the student's *Asthma Action Plan* if it varies from the standard asthma first aid response

Health condition	I seek approval from the principal/delegate for the student to self-administer:
☐ Asthma	☐ their asthma medication *(following a current action plan/health plan)*
☐ Anaphylaxis	☐ their adrenaline auto-injector *(following a current action plan/health plan)*
☐ Diabetes	☐ their medication *(following a current health plan)*
☐ Cystic fibrosis	☐ their medication *(following a current health plan)*
☐ Other _____	☐ their medication *(following a current health plan)*

Parent/carer/student signature		**Date**	