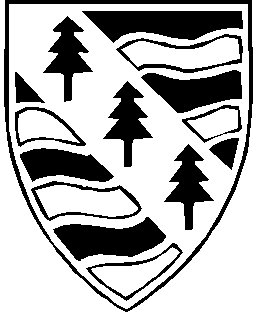
**TOKOROA HIGH SCHOOL**

**Procedure**

**Subject: EOTC Health profile and medical consent**



|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | |
| Name: |  | | | Medic Alert Number: | | |  | | |
| (if applicable) | | | | | | | | | |
| **1. Please tick if you have any of the following:** | | | | | | | | |
| Migraine | |  | Epilepsy | |  | Asthma | |  |
| Diabetes | |  | Travel sickness | |  | Fits of any type | |  |
| Chronic nose bleeds | |  | Heart condition | |  | Dizzy spells | |  |
| Colour blindness | |  | Other (Please specify) | | Click here to enter text. | | | |
| ADHD | |  |  | | | | | |
|  | | | | | | | | |
| **For overnight events** | | | | | | | | |
| Sleepwalking | |  | Bedwetting | |  |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| **2. Is your child currently taking medication?** | Yes |  |  | No |  |

|  |  |
| --- | --- |
|  | |
| If YES, please state: Health condition/s: | Click here to enter text. |
|  | |
| Name of medication/s: | Click here to enter text. |
|  | |
| Dosage and time/s to be taken: | Click here to enter text. |
|  | |
| Other Treatment: | Click here to enter text. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| **3.** Have you had any major injuries (breaks or strains) or illness (glandular fever etc) in the last six months that may limit full participation in any activities? | | | | | |
| Yes |  | No |  |  |
| If YES, please state the injury/illness: | | | | | |
| Click here to enter text. | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **4. Are you allergic to any of the following?** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | Yes | |  | | No | | | |  | | Please specify | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Prescription medication | | | | | | | |  |  | |  | |  |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Food | | | | | | | |  |  | |  | |  |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Insect bites/stings | | | | | | | |  |  | |  | |  |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Other allergies | | | | | | | |  |  | |  | |  |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| What treatment is required? | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **5. When was your child’s last tetanus injection?** | | | | | | | | | | Click here to enter a date. | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **6. Outline any dietary requirements:** Click here to enter text. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **7. If you agree to your child receiving any of the following medication please indicate by clicking on the boxes next to the type of medication.** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Panadol/Paracetamol | | |  | | Nurofen/Ibuprofen | | | | | | |  | | | | Disprin/Asprin | |  |  | |
|  | | | | | | | | | | | | | | | | | | | | |
| **8. To the best of your knowledge. Has your child been in contact with any contagious or infectious diseases in the last four weeks?** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Yes |  | No | |  | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| If YES, please give brief details | | | | | | | | | | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **9. Is there any information the staff should know to ensure the physical and emotional safety of your child? (For example cultural practices; disability; anxiety; about heights/darkness/small spaces; pregnancy; behaviour or emotional problems).** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Yes |  | No | |  | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| If YES, please state or attach the information. | | | | | | | | | | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| Tick | | | | |
|  | I agree that if prescribed medication needs to be administered, a designated adult will be | | | |
|  | assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened | | | |
|  | and handed to the designated adult with instructions on its administration. | | | |
|  | | | | |
|  | I will inform the school as soon as possible of any changes in the medical or other circumstances | | | |
|  | between now and the commencement of the event. | | | |
|  | | | | |
|  | I agree to my child receiving any emergency medical, dental, or surgical treatment, including | | | |
|  | anaesthetic or blood transfusion, as considered necessary by the medical authorities present. | | | |
|  | | | | |
|  | Any medical costs not covered by ACC or a community service card will be paid by me. | | | |
|  | | | | |
|  | If my child is involved in a serious disciplinary problem, including the use of illegal substances and/or alcohol, or actions that threaten the safety of others, s/he will be sent home at my expense. | | | |
|  | | | | |
| **To be read and signed by parent/caregiver of child participant.** | | | | |
|  | | | | |
| Signature: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | | | |
| Name: | | Click here to enter text. | Date: | Click here to enter a date. |