**TOKOROA HIGH SCHOOL**

**Procedure**

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



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|  |
| 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 |[ ]   |

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

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|  |
| 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. |

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| **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. |

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| **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. |

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|  |
| 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. |