**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) |  |
|  |
| ADHD |  |  |
|  |
| **For overnight events** |
| Sleepwalking |  | Bedwetting |  |  |

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

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

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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: |
|  |
|  |
|  |
|  |

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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?** |  |
|  |
| **6. Outline any dietary requirements:** |
|  |
|  |
|  |
|  |
|  |
| **7. If you don’t agree to your child receiving any of the following medication please indicate using a “🗶”. Either left blank of using a “✓” will signal consent.** |
|  |
| 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 |
|  |
|  |
|  |
|  |
| **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. |
|  |
|  |
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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: |  | Date: |  |