



Medical History

Student Name:

Date of Birth:

Community:

1. Does your child have any allergies including any food allergies

YES NO

If yes, please list below and describe the reaction (what happens if your child has this?).

2. Does your child have any of the following health conditions?

Diabetes

YES NO

Epilepsy or fits

YES NO

Kidney disease or kidney problems

YES NO

Asthma or breathing problems

YES NO

Rheumatic Heart Disease or other heart sickness

YES NO

Headaches/migraines

YES NO

Hearing problems

YES NO

Ear infection or perforation (hole in ear drum)

YES NO

Eye problem or vision problem

YES NO

3. If you ticked yes to anything above, does your child have treatment or medication for this?

If yes, what is it?

4. Does your child take any other medication? If yes, what are they?



Medical Consent

Student Name: [] Date of Birth: [] / [] / []

Medicare Number: [] [] [] [] [] [] [] [] [] [] [] Expiry Date: [] / [] / []

Student Home Address: LOT number: [] Community: []

1. Do you give consent for Tiwi College staff to give your child the following medications if required:

Paracetamol: YES [] NO [] Anti-inflammatory: YES [] NO [] Anti-histamine: YES [] NO []

If NO selected, please indicate course of action: []

2. Do you give permission for your health clinic to release or receive medical information of your child to or from Tiwi College? This includes information from GP's, nurses, hospitals and allied health professionals? (this information is kept strictly confidential) YES [] NO []

3. Do you give permission for your child to be assessed by GP's, nurses (including school nurse), hospitals, community care centres, allied health professionals and school psychologist? YES [] NO []

4. If your child is taking any medication, do you give permission for the Tiwi College Nurse to liaise with the local health clinic in picking up the medication and administrating at school as per the order given by the local health clinic (doctor or nurse)? YES [] NO []

5. In the event of an emergency and we are unable to contact a parent or guardian do you give permission for the school to act on your behalf to ensure appropriate medical, surgical or other healthcare treatment is preformed? (this may include emergency operations, blood transfusions and anaesthetic) YES [] NO []

6. Do you give permission for your child to have health checks at school, including review of vision, hearing and dental? YES [] NO []

7. Do you give permission for your child to have immunisations at school in line with the NT immunisation schedule for their age (including yearly influenza vaccine)? YES [] NO []

Parent/Guardian Name: []

Signature: []

Date: [] / [] / []