



**PLC ARMIDALE**

# STUDENT'S MEDICAL HISTORY

A history of your daughter's previous health before entering this school and while she is in attendance will enable the medical personnel to give her the best possible medical treatment. It is therefore important that all the questions be answered. Please ask your family doctor to assist you in answering the questions on this form and add any further medical details.

STUDENT NAME:	
DATE OF BIRTH:	
ADDRESS:	
HOME PHONE:	
WORK PHONE (MOTHER):	
MOBILE(MOTHER):	
WORK PHONE (FATHER):	
MOBILE (FATHER):	
FAMILY DOCTOR:	
DOCTOR PHONE & ADDRESS:	
FAMILY DENTIST:	
DENTIST PHONE & ADDRESS:	

**1. Has your daughter had any of the following diseases? (Circle the correct answer)**

Measles	Yes	No
Malaria	Yes	No
Rubella (German Measles)	Yes	No
Hepatitis	Yes	No
Chicken Pox	Yes	No
Glandular Fever	Yes	No
Mumps	Yes	No

Other (please specify): \_\_\_\_\_

**ALL STUDENTS ENTERING THE SCHOOL MUST PROVIDE A COPY OF IMMUNISATION RECORDS OR A DECLARATION OF EXEMPTION OR CONSCIENTIOUS OBJECTION SIGNED BY YOUR DOCTOR.**

**I HAVE PROVIDED A COPY OF IMMUNISATION RECORDS:**

PARENTS SIGNATURE:	
DATE:	

**2. Has your daughter had or does she suffer from any of the following? (Circle correct answer)**

Migraines/Headaches	Yes	No
ADHD	Yes	No
Diabetes	Yes	No
Fainting	Yes	No
Asthma	Yes	No
Deafness/Ear Infections	Yes	No
Epilepsy	Yes	No
Menstrual Disorders	Yes	No
Heart Disease	Yes	No
Whooping cough	Yes	No
Bone Disorders	Yes	No

Other (please specify): \_\_\_\_\_

If 'yes', please let us know what treatment she has had or is having:

\_\_\_\_\_

**3. Does your daughter suffer from asthma**                      Yes              No

If "Yes", please complete the Student Asthma record enclosed.

**4. PLC Armidale recommends all students have an eye examination and hearing test prior to commencing with us. Please provide details:**

	DATE COMPLETED	RESULTS
EYE EXAMINATION		
HEARING TEST		

5. Please list any injuries or operations your daughter has had. Give approximate date and details:

6. Is your daughter on any long term medication?                      Yes                      No

If yes, please list name and dose of drugs and condition for which drug is taken:

7. Is your daughter allergic to any of the following or have any skin conditions?

Penicillin	Yes	No
Food	Yes	No
Other Drugs	Yes	No
Does she suffer from Hayfever?	Yes	No
Other (e.g. pollen, mould)	Yes	No
Skin Conditions	Yes	No

If yes, please state name of allergy/condition and reaction:

Has you daughter ever been hospitalised for an allergic reaction	Yes	No
Has you daughter ever been given adrenaline for an allergic reaction	Yes	No

**NB: If “yes” to either of the last two questions, an appointment with the school nurse is required prior to starting school.**

**8. Medical Cover**

Does the student have private medical cover, e.g. Dental, optical?                      Yes                      No

If yes, name fund: \_\_\_\_\_

Does the student have private hospital insurance?                      Yes                      No

If yes, name fund: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Placement on card \_\_\_\_\_ Expiry Date \_\_\_\_\_

**Doctor's accounts will be sent directly to parents who pay the doctor direct. The school will not act as an intermediary in paying accounts.**

**9. Has your daughter had any counseling**                      Yes                      No

If "Yes" please provide details

**10. Other health issues the school should be aware of** (e.g. Special Needs or Disability; Learning Difficulties /Problems; Fainting; Hepatitis B Carrier; Incontinence):

**MEDICATIONS**

**All medications** for boarding students need to be handed to the House Mother at the start of each term.

**Non-prescription or "Over the Counter medications":**

Due to new Department of Health regulations (Pharmaceutical Branch) no medication may be given to students unless authorised and supplied as stated below by parents. Any other medications will need to be supplied to the Health Centre with your daughter's name and instructions for use.

**Prescription medication:**

Assistance will be given by the school nurse or house mother in their administration if requested by parents/guardians or as ordered by the school doctor.

The school nurse or house mother may only administer or assist with administration of these medications **IF** they clearly display the student's name, the required dosage and with its original container and label.

The school nurse or house mother, if required, will arrange for prescriptions to be filled at the local pharmacy. An account will be issued and is payable by parents/guardians.

**Restricted medication (e.g. Ritalin):**

Assistance will be given by the school nurse in the administration of Restricted medication after receiving documentation from the doctor and parent.

All medications will be stored in a locked cupboard in the Boarding House.

Instructions regarding changes to the original dosage of long term or restricted medications must be in writing from the doctor and parent/guardian.

**The following non-prescription medications are held in the Health Centre for the treatment of minor conditions and illness of ALL STUDENTS**

Please **initial beside EACH medication** that you authorise staff to administer to your child if required.

Antihistamine		Mylanta	
Anti-inflammatory gels		Naprogesic	
Antifungal creams		Nurofen Plus	
Burnaid		Panadeine	
Car sickness Medication		Panadol (paracetamol)	
Cold sore cream		Rehydration formula	
Cough medicine		Salbutamol (Ventolin)	
Eye Drops (for itchy red eyes)		Stingoes	
Heat rubs		Throat Lozenges	
Hirodoid		Throat Gargles	
Ibuprofen			

Please sign to authorise nursing staff and supervising staff on duty to administer this medication and first aid to your daughter if required:

PARENTS SIGNATURE:	
DATE:	

## MEDICAL CONSENT

I/WE (PRINT NAMES):	
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The undersigned provide the information contained in this form and consent to the procedure set out being followed in the event of injury to or illness of

NAME OF CHILD:	
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In particular I/we authorise you to obtain and assist in the administration of medications specified and any others as notified by me/us from time to time in writing on behalf of my/our child.  
I/we undertake to inform you of any changes to the information in this form, as and when necessary.

PARENT/GUARDIAN SIGNATURE:	
DATE:	
PARENT/GUARDIAN SIGNATURE:	
DATE:	

### Your attention is drawn to the last item on the "Conditions of Enrolment":

*In case of the need for urgent medical or hospital treatment for the pupil, and if her parents or guardians are not readily available, a member of the school staff is authorised to give authority for such treatment without the School or staff member incurring any legal liability to the parent, guardian or pupil. In this regard the parent or guardian hereby indemnifies the school, staff and Council against any claims which might arise as a result of such treatment.*

PARENTS SIGNATURE:	
DATE:	



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In alliance with **PLC SYDNEY**

OFFICE USE ONLY:	
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