CONFIDENTIAL MEDICAL FORM

Student Name ____

Date of Birth ____

Address ____

Telephone ____________________________ Mobile __________________________

Emergency Contact Persons

Name ________________________________ Telephone B/H ___________________

Relationship___________________________ Telephone A/H ___________________

Doctor _______________________________ Telephone _______________________

Insurance Fund ________________________ Health Fund No __________________

Ambulance Subscription (*Please tick box)* Yes ☐ No ☐

SubscriptIon Number _______________

Medical Information

Please tick the box **Yes** or **No** for the following questions:

Is the child currently taking any medication Yes ☐ No ☐

*Please specify*____

Does the child suffer from any of the following conditions?

Hayfever/allergies Yes ☐ No ☐

*If Yes, please specify*____

Diabetes	Yes ☐	No ☐	Nosebleeds	Yes ☐	No ☐
Blood Pressure	Yes ☐	No ☐	Epilepsy/Seizures	Yes ☐	No ☐
Heart Condition	Yes ☐	No ☐	Convulsions	Yes ☐	No ☐
Kidney Problems	Yes ☐	No ☐	Bowel Problems	Yes ☐	No ☐
Headaches/Migraines	Yes ☐	No ☐			

Any Other Conditions or Special Needs Yes ☐ No ☐

If yes, please specify:

____

____

____

Has the child been in contact with any infectious diseases in the last three months? Yes ☐ No ☐

If yes, please specify:

____

____

____

I authorise Guardianship Australia's authorized officer to consent to my child receiving medical treatment as may be deemed necessary. I further agree to meet all costs of such treatment.

I declare that the information which has been provided on this form is true and complete.

PARENT/GUARDIAN ____

SIGNATURE ____

DATE ____