

Name:
Class:
Parent Signature:



OFFICE USE ONLY
Date Received:
Date Entered:

Mueller College

Medical Details Form

Please ensure that this form is filled out correctly and returned to the school office prior to your child starting for the school year.

In the interests of your child's welfare we ask that you complete this form. The information provided by you in this document will be treated as strictly confidential and will only be shared with the relevant staff members when necessary.

The school suggests that you retain a copy of this form for your records. Please fill out this form as completely as possible as this would assist us in the event of a medical emergency. Should you have any changes to your child's details, please inform the school in writing.

Mueller College
75 Morris Rd
ROTHWELL QLD 4022. AUSTRALIA.
Phone: (07) 3897 2990 Fax: (07) 3204 0404
schoolnurse@mueller.qld.edu.au
ABN: 48 011 019 113

Student Information

* Denotes a required field

Family Name: _____

Given Name(s): _____

Preferred Name *: _____

Date of Birth *: _____

Religion: _____

Boarder: Yes / No (Please circle)

Medical / Other Information

Ambulance: Yes / No (Please circle)

Paracetamol: Yes / No (Please circle)

Immunisation: Yes / No (Please circle)

Conscientious Object: Yes / No (Please circle)

Private Health: _____

Medical Form: _____

Private Health No: _____

Medicare No: _____

Medical Practitioners

Doctor _____ **Phone:** _____

Immunisations (Past 12 months)

Tetanus: Yes / No (Please circle) **Year:** _____

Swimming Ability

Please select the most accurate description of your child's swimming ability.

- Advanced can swim 50 metres
- Beginner can swim a little
- Intermediate can swim a few metres on own
- Non swimmer not confident

Other Current Medication

Medication (e.g. Multivitamins)	Method (e.g. orally)	Details

Supplementary Information

Does your child require any of the following items? If answering 'Yes' please provide your child with the necessary items.

I hereby acknowledge that the information provided is accurate.

Signature of Parent / Guardian (Please circle) _____

Please print your name _____

Date ____ / ____ / ____

Appendix A: Medical Conditions

Allergy	Yes / No (Please circle)	Additional details: _____
Anaphylaxis	Yes / No (Please circle)	Additional details: _____
Asthma	Yes / No (Please circle)	If 'Yes', please complete APPENDIX B: Asthma Management Plan. This form must be completed and signed by your doctor. Additional details: _____
Diabetic	Yes / No (Please circle)	Additional details: _____
Drug Allergy	Yes / No (Please circle)	Additional details: _____
Epilepsy	Yes / No (Please circle)	Triggers: _____
Food Allergy	Yes / No (Please circle)	Additional details: _____
Learning Assistance	Yes / No (Please circle)	Additional details: _____
Medical Conditions	Yes / No (Please circle)	Additional details: _____
Mental Health	Yes / No (Please circle)	Additional details: _____
Parent Notification	Yes / No (Please circle)	Additional details: _____

CONFIDENTIAL
Appendix B: Asthma Management Plan

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner).
Parents/carers should inform the school immediately if there are any changes to the management plan.
Please tick the appropriate box and print your answers clearly in the blank spaces where indicated.

Student's Name: _____ **Age:** _____

Date of Birth: _____ **Form/Class:** _____ **Gender:** _____

Emergency Contact: _____

Home Ph: _____ **Work Ph:** _____ **Mobile 1:** _____

Mobile 2: _____ **Doctor Name:** _____ **Phone(BH):** _____

Mobile/Pager: _____ **Ambulance Sub:** _____ **Yes / No (Please circle)** _____ **Subscriber No: #** _____

Medicare No: # _____

Usual signs of student's asthma	Worsening signs	Triggers
Wheezing	Wheezing	Exercise
Tightness in chest	Tightness in chest	Colds/Viruses
Coughing	Coughing	Pollens
Difficulty breathing	Difficulty breathing	Dust
Difficulty speaking	Difficulty speaking	Food
Other:	Other:	Which Foods?
_____	_____	_____
_____	_____	_____
_____	_____	Other Triggers:
_____	_____	_____
_____	_____	_____

Does your child need assistance taking their medication? **Yes / No (Please circle)**

Any other information that will assist with the asthma management of the student?
e.g. peak flow action plan, night time asthma, recent attacks (attach additional information if necessary)

What is the usual medicine regime followed?

**Medication Requirements:
(including preventers, symptom controllers, medication before exercise)**

Name of Medication	Method (e.g. puffer & spacer, turbuhaler)	Details

Asthma First Aid Plan

Please tick the preferred First Aid Plan

Victorian Schools Asthma Policy for Emergency Treatment of an Asthma Attack:

**Section 4.5.7.8 of The Department of Education
Schools of the Future Reference Guide**

1. Sit the student down and remain calm to reassure the student.
2. Without delay give 4 puffs of a Reliever Inhaler (Ventolin, Respolin or Bricanyl), using a spacer. Spacer technique equals 1 puff, then take 4 breaths from spacer, repeat until 4 puffs have been given.
3. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per step two.
4. If there is no improvement, call an ambulance (000) immediately and state that "a student is having an asthma attack".
5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

OR

Student's Emergency Treatment (if different from above):

- In the event of an asthma attack at school, I agree to my child receiving the treatment described above.
- I authorise school staff to assist my child with taking asthma medication should they require help.
- I will notify you in writing if there are any changes to these instructions.
- Please notify me if my child regularly has asthma symptoms at school.
- Please notify me if my child has received asthma first aid.
- I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent / Guardian Signature: _____

Date: ____ / ____ / ____

Doctor's Signature: _____

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly Schools Program and asthma management please contact: Asthma Victoria on (03) 9326 7088 or Toll Free 1800 645 130 or visit our web site www.asthma.org.au.

