



# Glenfield Intermediate School

## Student Health Information

Student's Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

To help us care for your child in any illness or emergency situation, would you please answer the following questions. This information will be strictly confidential (Privacy Act 1993) and will only be revealed to necessary staff members to ensure the safety of your child. If you wish to discuss any health concerns further – contact Sandy Peal on 444 6582 ext 802.

1. Family Doctor: \_\_\_\_\_ Phone No \_\_\_\_\_

2. **Existing Medical Conditions** (Please circle) Medication Required

Asthma	Yes/No _____
Diabetes	Yes/No _____
Epilepsy	Yes/No _____
Rheumatic Fever	Yes/No _____
Hepatitis A, B, or C	Yes/No _____
HIV	Yes/No _____
Glandular Fever	Yes/No _____
Migraines	Yes/No _____
Heart Conditions	Yes/No _____
ADHD	Yes/No _____
Nose Bleeds	Yes/No _____
Recurring Abdominal Pain	Yes/No _____
Back/Neck Problems	Yes/No _____
Past Illness or Operations	Yes/No _____
Skin Condition	Yes/No _____
Other	Yes/No _____

**Asthma Sufferers Only:**

Reliever: \_\_\_\_\_ Preventer: \_\_\_\_\_

Has your child been hospitalised with Asthma? \_\_\_\_\_

Does your child have an Asthma Action Plan? \_\_\_\_\_

If "yes", please give a copy to the school office. If your child is using preventers, the Asthma Society recommends having an Action Plan (requires updating every 6 – 12 months).

3. Allergies	Specify Reaction (mild/moderate/life threatening)	Treatment
Bee/Wasp Stings	Yes/No _____	_____
Medication	Yes/No _____	_____
Food	Yes/No _____	_____
Other	Yes/No _____	_____



# Glenfield Intermediate School

Further details \_\_\_\_\_

---

---

#### 4. **Medication:**

If a child requires special medication at school, a Medical Consent form must be filled out. Medication must be labelled clearly and instructions explicit. Medication will be kept in the Health and Well-Being Room.

5. Does your child regularly have?

- (a) Any medication not mentioned above?
- (b) A course of treatment/counselling?

Please give details: \_\_\_\_\_

---

6. Sensory Loss: Does your child need to wear glasses or a hearing aid? Please give details:

---

---

Does your child need to sit in the front of the class because of this? \_\_\_\_\_

7. Other relevant conditions: Is there anything that may prevent your child taking part in any school activities?

---

---

8. Special Home Circumstances: Are there any factors that may affect the student's behaviour or emotional stability?

---

---

#### **Medication:**

I give permission for Panadol to be administered if required. Yes  No

Parent / Caregiver Signature: \_\_\_\_\_