Mackay Christian Colleges Ltd t/a

Mackay Christian College

a place where you belong

ABN 22 010 555 389 CRICOS 01085D

STUDENT MEDICAL RECORD

Please complete a separate record for each

Student's Surname: Date of Birth: Year Level:

Student's First Name/s: Phone:

Address:

Does Student Live with both Parents: ☐ Yes ☐ No If no, with:

Father's name: Phone: Mobile:

Mother's Name: Phone: Mobile:

In an emergency, which parent should be contacted first?

Other Emergency Contact:

(The person we can contact if parents are not available) Relationship:

Medical Information

Parents must complete a Notification/Request to administer medication form when providing medication

Doctor's/Hospital Name: Phone:

Doctor's/Hospital Address:

Medicare No: Private Health Cover: Yes ☐ No ☐

Company: Number:

Asthma	☐ Yes Please complete student Asthma record	☐ No	**Eczema**	☐ Yes	☐ No
Mild/Moderate/ Severe			Management		
Normal peak flow			**Epilepsy**	☐ Yes	☐ No
Induced by			Type		
Medication:	* To be provided to the College		Seizures induced by:		
Blood Disorders	☐ Yes	☐ No	Medication	* To be provided to the College	
Type			Frequency of seizures		
Emergency Management			Date of last seizure		
Cardiac Condition	☐ Yes	☐ No	**Hay Fever**	☐ Yes	☐ No
Type			Induced by		
Medication	* To be provided to the College		Medication	* To be provided to the College	
Emergency Management			**Headaches**	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Frequency		
Type			Medication	* To be provided to the College	
Current Medication	* To be provided to the College		**Migraine**	☐ Yes	☐ No
Hearing/sight condition(grommets/glasses)	☐ Yes	☐ No	Frequency		
Details			Medication	* To be provided to the College	

Please complete both sides of this form.

Ankle/Back/Knee/Joint Problems	❒ Yes If yes, please describe	❒ No
Management		
Previous surgery		
Any other condition or relevant medical information not covered above		
Management		
Medication	*To be provided to the College	

Allergic Reaction Management Plan

Name of Student: _____ Date of Birth: _____

Allergies e.g. Latex (bandaids) Animals, Bee Stings etc: _____

_____

Signs and symptoms of reaction: _____

What medication is taken (if any) for the prevention of allergic reaction: _____

What treatment is followed if an allergic reaction occurs: _____

_____

Has the student at any time in the past suffered from:

❒ A localised reaction (any rash/itching/swelling at the site poison entered)

❒ A Systematic reaction (any rash/itching/swelling away from the site poison has entered)

❒ An Anaphylactic reaction (severe breathing problems, swelling of body, emergency situations)

1.	Does the student suffer a systemic/anaphylactic reaction to allergy?	❒ Yes	❒ **No**
2.	Is there a family history of anaphylaxis?	❒ Yes	❒ **No**
3.	Has the student been admitted to hospital for an allergic reaction and/or asthma?	❒ Yes	❒ **No**
4.	Does the student take adrenaline (Epi-Pen) when suffering from an allergic reaction?	❒ Yes	❒ **No**

If "Yes" was the answer to any of Questions 1 – 4, the student's Medical Practitioner must be consulted and documents from the Medical Practitioner on the student's allergy management and emergency routine provided.

In case of an emergency, I grant the College permission to seek any necessary medical assistance and forward relevant medical history listed on this record to the attending Medical Officer.

Signature of Parent/Guardian: _____ Date: _____

Office Use Only: Follow up required:

Signed: _____ Date: _____