DEUTSCHE SCHULE MELBOURNE
MEDICAL INFORMATION AND CONSENT FORM

STUDENT DETAILS

Name ______________________________
Date of Birth ______________ Religion ______________
Medicare Number __________ Expiry Date __________ Position __________
Private Health Fund ______________________________

PARENT CONTACT DETAILS

Mother (H) __________ (W) __________ (Mob) __________ Email __________
Father (H) __________ (W) __________ (Mob) __________ Email __________

EMERGENCY CONTACT DETAILS (other than parents/guardians)

Name ______________ Relationship to student __________
(H) __________ (W) __________ (Mob) __________ Email __________
Address ______________________________

Name ______________ Relationship to student __________
(H) __________ (W) __________ (Mob) __________ Email __________
Address ______________________________

FAMILY DOCTOR DETAILS

Name ______________________________
Address ______________________________
Telephone______________________________
Anbulance Member Yes ☐ Number __________ No ☐

IMMUNISATION RECORD

Yr of last Tetanus or ADT or DtPA Booster __________ Year of last Polio Booster __________
Yr of last Measles/Mumps/Rubella: __________ Year of Chicken Pox Vaccine __________
Yr of last Hepatitis B vaccination Year of Meningococcal Vaccine __________
Other ______________________________

CHILDHOOD DISEASES (tick if your child had any of the following)

Chicken Pox __________ Glandular Fever __________ Mumps __________
Measles __________ German Measles __________ Whooping Cough __________
Croup __________ Other (pls specify) ______________

CONFIDENTIAL MEDICAL HISTORY

If your child suffers from any of the following, please complete the separate relevant Medical Management Plan(available at DSM's website www.dsm.org.au) AND ensure this plan is signed by a Doctor

Asthma __________ Diabetes __________ Epilepsy __________ __________
Anaphylaxis___________ Allergy ______________

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

- [ ] Localised Reaction (any rash, itching, swelling at the site the toxin has entered)
- [ ] Systemic Reaction (any rash, itching, swelling at the site the toxin has entered)
- [ ] Anaphylactic Reaction (severe breathing problems, swelling of the body, emergency situation).

Other (please specify and attach any relevant information)

____

OTHER HEALTH ISSUES THE SCHOOL SHOULD BE AWARE OF

E.g. Hepatitis B carrier, psychological problems, special needs/disability, hearing, visual impairment any recent operations or injuries (give details and approx. dates):

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____

PRESCRIPTION MEDICATION/CURRENT TREATMENTS

List **PRESCRIPTION MEDICATIONS**, their dose and frequency that your child is currently taking **AND** any current treatment(s) the school should be aware of:

____

____

____

NECESSARY INFORMATION

Can your child swim 50m without stopping ________ Yes ________ No

Can your child ride a bike ________ No ________ Struggles ________ Comfort.

Are there any other factors which may affect participation in physical activities, excursions, or school camps? ____

____

Does your child have any special dietary requirements? ____________________

____

Is there any other information we should be aware of? ____________________

____

SCHOOL PROCEDURES IN THE EVENT OF ACCIDENT OR ILLNESS

DSM has developed a set of policies and procedures which will be followed in case of accident or illness. These policies are available at www.dsm.org.au and are titled as follows:

Arrangements for Ill Students

Administration of Medication

Anaphylaxis

I/we ______________________________________ (print names) of

address ____

____

being the parent(s)/guardian(s) of ______________________________________

(student's name) provide the information as requested in the Confidential Medical History section of this form.

I/we consent to the School administering First Aid and arranging medical treatment in the event of an emergency and indemnify the school for the cost of any such treatment

I/We consent to the administration of medication in accordance with my child's Medical Management Plan and any others as notified by me/us, in writing in accordance with DSM policy on Administration of Medication

I/we authorise you in the event of injury to or illness to our child/guardian to follow the procedure(s) set out in the DSM policies and procedures at www.dsm.org.au.

I/we undertake to inform you in writing of any changes to the information in this form as and when necessary.

Signed: ____ Date: ____________________
(parent/guardian)

Signed: ____ Date: ____________________
(parent/guardian)