Medical / Health / Photos Authorisation Form

Student Information

Name: **Year Level:** **LC:**

Address: **Date of Birth:**

Student Email: **Student Cell Phone:**

1 Please tick if your child has any of the following:

☐ Migraine
☐ Epilepsy
☐ Asthma
☐ Diabetes
☐ Travel Sickness
☐ Fits of any type
☐ Chronic Nose Bleeds
☐ Heart Condition
☐ Dizzy Spells
☐ Colour Blindness
☐ Other – Please Specify

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2 Medical Alert Number (if applicable)

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3 Date of last tetanus injection? (if known)

……../……../……..

4 Is your child currently taking medication?

☐ No
☐ Yes – Please state ailment/s

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……

Name of medication/s

……

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Dosage & time/s to be taken

……

……

Other treatment

……

……

5 Has your child had any major injuries (breaks or strains) or illness (glandular fever etc.) in the last six months that may limit full participation in any activities?

☐ No
☐ Yes – Please specify

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6 Is your child allergic to any of the following?

Prescription medication
☐ No
☐ Yes – Please specify

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……

Food
☐ No
☐ Yes – Please specify

……

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Insect bites/stings
☐ No
☐ Yes – Please specify

……

……

Other allergies
☐ No
☐ Yes – Please specify

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Treatment required?

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7 Outline any dietary requirements?

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8 What pain/flu medication may your child be given if necessary?

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9 To the best of your knowledge, has your child been in contact with any contagious or infectious diseases in the last four weeks?

☐ No
☐ Yes – Please give brief details

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10 Is there any other information that staff should know to ensure the physical and emotional safety of your child? (Eg. Cultural practices, disability, anxiety about heights/darkness/small places, pregnancy, behavioural or emotional problems)

☐ No
☐ Yes – Please give brief details

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Please take time to update health information with the school office if there are any changes during the year.

Student Name	
Parents/Caregivers Name	**Phone Number (cellphone)**
1.	
2.	
Emergency Contact Name	**Phone Number (cellphone)**
Family Doctor/Medical Centre Name	**Phone Number**
Dentist/Dental Clinic Name	**Phone Number**
Student Name	

I/We the undersigned, who are the legal guardians and caregivers for the above-named student, do authorise the following:

- Should my child be hurt whilst at school or on a school outing, I/we give permission for First Aid Certified staff, or if unavailable, other school staff, to assess and administer appropriate medical treatment. If considered further medical professional assistance is required, every attempt will be made to contact us immediately. Yes/No

- If I/we are unavailable, we authorise medical professionals to administer appropriate medical treatment to the above-named student when accompanied by a Totara College staff member or person authorised by Totara College. I/we will accept responsibility to pay any associated medical costs. I/we understand I/we, or my emergency contact will be contacted and informed as soon as practicably possible. Yes/No

- I/we authorise the administration of non-prescription medication should they be required, that is, Panadol tablets (500 mg Paracetamol) or Pamol syrup (250mg Paracetamol). Yes/No

- I/we authorise the administration of non-prescription medication supplied from home. This will be accompanied with clear written instructions. Yes/No

- I/we authorise the administration of prescription medicine according to the prescription instructions and to be administered according to my/our clear written instructions. Yes/No

- Should head-lice be detected in the class, I/we authorise the Public Health Nurse or a member of Totara College staff to inspect my child's hair. Yes/No

- I/we authorise Totara College to publish images and first name of my child on the Totara College website and Facebook. Permission will be sought if their surname is to be used. Yes/No

- I/we authorise Totara College to submit photos of my child to local newspapers for publication. Yes/No