

## TSB TOPEC Medical Health Profile

Name

Medic Alert number

(if applicable)

1. Please tick if you have any of the following:

Migraine	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Travel sickness	<input type="checkbox"/>	Fits of any type	<input type="checkbox"/>
Chronic nose bleeds	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>
Colour blindness	<input type="checkbox"/>	Other (please specify)			

2. Are you currently taking medication?

Yes  No

If YES, please state: Ailment/s

Name of medication/s:

Dosage and time/s to be taken

Other treatment:

3. Have you 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? Yes  No

If YES, please state the injury/illness.

4. Are you allergic to any of the following?

	Yes	No	Please specify
Prescription medication	<input type="checkbox"/>	<input type="checkbox"/>	
Food	<input type="checkbox"/>	<input type="checkbox"/>	
Insect bites/stings	<input type="checkbox"/>	<input type="checkbox"/>	
Other allergies	<input type="checkbox"/>	<input type="checkbox"/>	
What treatment is required?	<input type="checkbox"/>	<input type="checkbox"/>	

5. When was your/your child's last tetanus injection?

6. Outline any dietary requirements.

  

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

8. To the best of your knowledge, have you/your child been in contact with any contagious or infectious diseases in the last four weeks?

Yes  No

If YES, please give brief details.


9. Is there any information the staff should know to ensure the physical and emotional safety of you/your child? (For example cultural practices; disability; anxiety about heights/darkness/small spaces; pregnancy; behaviour or emotional problems).

Yes  No

If YES, please state or attach the information.


**Emergency Contact Details**

Relationship to student:


I also agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration.

I will inform the school as soon as possible of any changes in the medical or other circumstances between now and the commencement of the event.

I agree to my child/myself receiving any emergency medical, dental, or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

Any medical costs not covered by ACC or a community service card will be paid by me.

If my child is involved in a serious disciplinary problem, including the use of illegal substances and/or alcohol, or actions that threaten the safety of others, s/he will be sent home at my expense.

Print name

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Signed

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To be read and signed by adult participant or parent/caregiver of child participant.

Date

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