SCOTS ALL SAINTS COLLEGE

Medical History and Consent Form

Student's surname (please print) Date of birth / /	First names School year group Date of entry / / Day student/Boarder
Mother's Name Address Post code	Email Phone (H) (W) Mobile Fax
Father's Name Address Post code	Email Phone (H) (W) Mobile Fax

Medicare number											**Expiry Date**	Month	Year	Position on card	

Private Health Fund	**Emergency and or/guardian name, address, phone (other then listed above)**

Doctor's Name Phone	**Dentist/Orthodontist** Phone

Please state briefly any HEALTH ISSUES, MEDICAL ALERTS or SPECIAL NEEDS that staff need to be aware of. Including any potentially serious or life threatening condition.

Information on this page will be sent to the Head of House, Nurse, Counsellor, and relevant teaching staff. Please sign to acknowledge that you agree to this. **SIGN:**

MEDICAL CONSENT

To: The Head of College

I /we: ______________________________
(parent/guardian- please print names)

being the parent/guardian of ______________________________
(please print name of student)

consent to the administration of medications specified in Section One (over page) and any others as notified by me/us in writing as required and also provide the information as requested in Section Two of this form.

I/we authorise you in the event of injury to or illness of our child/ward, to follow the procedure(s) set out in Section One (over page) of this consent.

I/we undertake to inform you of any changes to the information contained in this form as and when is necessary. This consent shall remain valid unless withdrawn and notified by myself/us in writing to the College.

Signed ______________________ Date ______________ (parent/guardian)

Signed ______________________ Date ______________ (parent/guardian)

SCHOOL PROCEDURES IN EVENT OF ACCIDENT OR ILLNESS

Minor ailment

- The student will report to the health centre where his/her attendance will be recorded on the daily register.
- The school nurse on duty will assess and treat the student as required. If further care is required for day students, parents will be notified.

Minor injuries

- Student to report to the health centre where assessment and first aid will be administered.
- If the student is injured whilst playing sport he/she should report to the coach/teacher in the first instance and then to the registered nurse on duty.
- Treatments will be documented in personal medical records and in the student's diary if presented.

Serious illness / injury requiring doctor or hospital

- The parent/guardian will be contacted if at all possible according to the information available on the medical form.
- The school nurse will be called to the site of the injury/illness if at all possible and/or, if appropriate, the student transferred to the health centre where first aid will be administered.
- The nurse on duty or other member of school staff (if the nurse is not available) will assess the student and if required the student will be transported to the doctor/hospital.
- In an emergency or on the advice of an attending doctor, the student will be taken by ambulance or other suitable vehicle to the nearest available hospital.
- In the event of injury or illness to a student requiring urgent hospital or medical treatment including but not limited to injections, blood transfusions and the like and where a parent or guardian is not readily available to authorise such treatment the school nurse or other member of school staff (if the nurse is not available) is authorised to give the necessary authority for such treatment without the school or such staff member or any other employee or agent of the school incurring any liability to the student, parent or guardian in so doing.
- The parents or guardians agree to be liable for and indemnify the school, its employees and agents in respect of all costs and expenses arising directly or indirectly out of such treatment.

Medication procedures

- Parents are requested to inform the health centre of any medications being taken by students.
- All medications taken during the school day should be stored in the health centre unless other arrangements are made with nursing staff.
- All medications administered by the school nurse will be recorded.

Prescription and restricted medications

- Assistance will be given by the school nurse in the administration of prescribed medication, when requested in writing by parents/ guardians or as prescribed by the school doctor.
- Assistance will be given by the school nurse in the administration of restricted medication (such as Ritalin, Dexamphetamine) after receiving documentation from the doctor and parent.
- Instructions regarding changes to the original dosage of long term or restricted medications must be in writing from the doctor and parent/guardian.
- The school nurse may only administer or assist with the administration of any medication IF the medication is provided in its original container with label clearly displaying the student's name and the required dosage.
- All medications will be stored in a locked cupboard in the health centre.

Non-prescription or 'over-the-counter' medications

The following non-prescription medications are held in the health centre for the relief of minor pain, coughs, colds, fever.

Paracetamol	Ibuprofen	Travel sickness tablets
Eye Drops	Skin lotion/ Ointments	Naprogesic
Antihistamine	Throat Lozenges	Gastrolyte

☐ YES I give permission for these medications to be administered

☐ NO I don't give permission for these medications to be administered. Please contact Parents/carers prior to administrating any medication

Please write below any other non-prescription medications that your child may need and the name of the condition these will need to be supplied to the Health Centre if they are or may need to be taken at school

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

1. IMMUNISATION RECORD

Please attach a current vaccination record or Doctor's Certificate or Conscientious Objectors Form.

2. CHILDHOOD DISEASES please tick any which the student has had

☐ Chicken pox ☐ Glandular Fever ☐ Mumps ☐ Rubella (German Measles)

☐ Croup ☐ Whooping Cough ☐ Measles ☐ Rheumatic fever

☐ Other (please specify) ____

3. MEDICAL HISTORY does the student suffer from:

Diabetes? ☐ YES or ☐ NO Anaphylaxis? ☐ YES or ☐ NO Epilepsy? ☐ YES or ☐ NO

Other health issues that the school should be aware of (eg. Special needs or disability, learning difficulties/problems, fainting, Epilepsy, Incontinence):

____

____

4. ANY COUNSELLING OR PSYCHOLOGICAL ISSUES THE SCHOOL SHOULD BE AWARE OF

____

____

5. PRESCRIPTION MEDICATIONS list any prescription medications that your child is currently taking.

Medication	Dosage	Frequency

6. ALLERGIES AND TREATMENT REQUIRED Allergy/Anaphylaxis Plan to be supplied annually

MEDICATIONS ____

FOOD ____

INSECTS ____

OTHER ____

8. CURRENT TREATMENTS THAT THE SCHOOL SHOULD BE AWARE OF

____

____

9. DOES YOUR CHILD HAVE HEARING OR SIGHT DIFFICULTIES eg glasses

____

10. DO YOU REQUIRE AN APPOINTMENT WITH the ☐ School Nurse or ☐ Counsellor

11. ASTHMA HISTORY (Please provide an Asthma Action Plan annually)

Does your child suffer from asthma? ☐ YES or ☐ NO

If yes has your child been to hospital due to asthma in the past two years? ☐ YES or ☐ NO

Has your child been treated with oral cortisone in the past 12 months? ☐ YES or ☐ NO

Does your child have an asthma action plan? (if yes please attach) ☐ YES or ☐ NO

Student's current reliever is ________________________ Current preventer______________________

Other medication taken for asthma? ____

Student Asthma Record (to be completed for all students with asthma)

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner). Parents/carers should inform the school immediately if there are any changes to the management plan. Please tick (/) the appropriate box, and print your answers clearly in the blank spaces where indicated.

Personal Details

Student's name: .... Gender: M ☐ F ☐
(SURNAME) (FIRST NAME)

Date of birth: / / Form/Class: .... Teacher: ....

Emergency contact (e.g. parent, carer):

a. Name .... Relationship ....

Telephone No: .... (Hm) .... (Wk)

b. Name .... Relationship ....

Telephone No: .... (Hm) .... (Wk)

Doctor: .... Telephone No. ....

Usual Asthma Management Plan

Child's symptoms (e.g. cough): ....

Triggers (e.g. exercise, pollens): ....

Medication requirements:

Name of Medication	Method (e.g. puffer & spacer, turbuhaler)	When, and how much?

In an **Emergency** follow the Plan below that has been ticked (✓)

☐ **Standard Asthma First Aid Plan**

Please tick (✓) the preferred box

Step I Sit the student upright, remain calm and provide reassurance. Do not leave student alone.
Step 2 Give 4 puffs of a blue reliever puffer (Airomir, Asmol, Epaq or Ventolin), one puff at a time, preferably through a spacer device*. Ask the student to take 4 breaths from the spacer after each puff.
Step 3 Wait 4 minutes.
Step 4 If there is little or no improvement, repeat steps 2 and 3.
If there is still little or no improvement, call an ambulance immediately (Dial 000).
Continue to repeat steps 2 and 3 while waiting for the ambulance.
** Use a blue reliever puffer on its own if no spacer is available. A Bricanyl Turbuhaler may be used in first aid treatment if a puffer and spacer are unavailable.*

OR

☐ **My Child's Asthma First Aid Plan (attached)**

Additional comments:

....

....

I authorise school staff to follow the preferred Asthma First Aid Plan and assist my child with taking asthma medication should they require help. I will notify you in writing if there are any changes to these instructions. Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms at school.

Signature of Parent/Carer: .... **Date:** ....

I verify that I have read the preferred Asthma First Aid Plan and agree with its implementation.

Signature of Doctor: .... **Date:** ....