Section 3

MEDICAL DISCLOSURE DECLARATION

Child's Name: ______________________________ DOB ____________________

Emergency Contacts:

Name: ________________ Ph (BH): ________________ Ph (AH) ________________

Relationship: ____

Name: ________________ Ph (BH): ________________ Ph (AH) ________________

Relationship: ____

Name: ________________ Ph (BH): ________________ Ph (AH) ________________

Relationship: ____

Family Doctor: ______________________ Practice: ______________________

Address: ________________________________ Phone: ________________

Family Dentist: ______________________ Practice: ______________________

Address: ________________________________ Phone: ________________

If needed, my child (under direct supervision of the staff member) may be given:

☐ Panadol. ☐ Ventolin.

Other ____

My child is allergic to the following medications or ingredients:

My Child is currently on the following medication:

Provide a history of any relevant medical condition/s with type and dosage of medication:

Are you aware of any special needs your child may have?

Has your child had their hearing and sight checked? ☐ Y. ☐ N.

Detail any problems:

Has your child been referred to any of the following services and if so which ones?

Early Childhood intervention service ECIS? ☐ Y. ☐ N.

If yes, please provide details, who, address and when:

____

____

Speech therapist? ☐ Y. ☐ N.

If yes, please provide details, who, address and when:

____

____

Physio therapist? ☐ Y. ☐ N.

If yes, please provide details, who, address and when:

____

____

Occupational therapist? ☐ Y. ☐ N.

If yes, please provide details, who, address and when:

____

____

Psychologist? ☐ Y. ☐ N.

If yes, please provide details, who, address and when:

____

____

Paediatrician? ☐ Y. ☐ N.

If yes, please provide details, who, address and when:

____

____

Other ____

If yes, please provide details, who, address and when:

____

____

Please attach any reports you have from any of the above services to the school.

Have you applied for the National Disability Insurance scheme NDIS funding? ☐ Y. ☐ N.

If successful, what services are you able to access to support your child?

____

____

____

____

____

Does your Child suffer from Asthma? ☐ Y. ☐ N.

If yes, please provide a copy of the Asthma Treatment Plan for any treatment required on a form available at the school office.

Does your Child suffer from allergies? ☐ Y. ☐ N.

If Yes, please provide a copy of the Allergy Treatment Plan for any treatment required on a form available at the school office.

Is your child's immunization up to date? Y ☐ N ☐

Please provide a copy of the immunization record.

Are there are any physical impairments or special instructions for your child? ☐ Y. ☐ N.

If yes please specify:

____

____

____

Does your child have a learning plan from your previous school? ☐ Y. ☐ N.

If yes, please provide a copy.

Declaration:

I,____________________, hereby declare that the above medical information is true and correct and complete.

Parent/Guardian Signature ________________________________ Date: _______________