KINCOPPAL – ROSE BAY
SCHOOL OF THE SACRED HEART

Student / Health Information
Medical Consent Form – Student Exchange Program 2012/2013

(The information on this form is considered confidential)

Medical/Personal information listed here will be used to organise exchange, support the care of students while on exchange and to assist communication with parents/guardians in case of emergency.

Student Information		
Name (Full name as shown on Passport)		
Date of Birth	**Age**	**Year Level**
Address		
Passport Number	**Country of Issue**	**Expiry Date**

Contact People in Emergency

Parent/Other Person contact details for the duration of the Overseas Tour
(Please note that the 'Other Person' nominated by you will be the person whom we contact in the event of an emergency when we are unable to contact parents.)

	Mother	**Father**	**Guardian/or Other Relative (State Relationship)**
Name			
Telephone			
Home			
Business			
Mobile			
Email			
Facsimile			

Medical Information/History		
Blood Type		
Name of Doctor		**Telephone**
Address of Doctor		
Overseas Travel Insurance	**Policy With**	**Policy No**

Immunisation

1. Has your child been adequately and currently immunised against?

Polio	Yes ☐	No ☐	Measles, Mumps, Rubella	Yes ☐	No ☐
Meningococcal	Yes ☐	No ☐	Hepatitis B	Yes ☐	No ☐
Tetanus, Diphtheria, Pertussis (Whooping Cough)				Yes ☐	No ☐

2. Has your child been immunised against Hepatitis A? Yes ☐ No ☐
3. Has your child been immunised against Typhoid? Yes ☐ No ☐
4. Please provide a copy of your child's immunisation record to assist at the visiting school Yes ☐ No ☐

Allergies

Does your child suffer from allergies? Yes ☐ No ☐

Give details of any:

☐ drug-related allergies (e.g. Penicillin).....

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Give details of any:

☐ food-related allergies (e.g. peanuts).....

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☐ dietary guidelines or special food requirements while on tour (e.g. vegetarian).....

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☐ environmental allergies (e.g. plants, animals, bee/wasp stings).....

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Current Management Plan.....

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Please provide a copy of your child's current management plan detailing your doctor's current treatment.

Required Medications

Does your child suffer any conditions requiring medication (e.g. epilepsy, asthma)? Yes ☐ No ☐

If YES, please supply a doctor's letter detailing the condition, the medication and required dosage and the name and contact number of the treating doctor.

Details.....

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Current Management Plan:.....

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Please provide a copy of your child's current management plan detailing your doctor's current treatment.

Physical Disabilities/Conditions

Does your child suffer any physical disabilities or conditions (e.g. poor eyesight, air or car travel sickness, period pain), history of previous operations/serious injuries? Yes ☐ No ☐

If YES, give details of condition/s and usual treatment.

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Emotional/Psychological Conditions

Does your child suffer any emotional/psychological conditions (e.g. homesickness, phobias)? Yes ☐ No ☐

If YES, give details of the condition and how it is managed.

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Authority for Medical Treatment

In an emergency, I authorise the staff of Kincoppal-Rose Bay School to consent to my child receiving such medical treatment as is necessary, including hospitalisation, surgery, and blood transfusion and anaesthetic. In doing so, I agree to pay any medical, hospital, nursing, ambulance, travel, medication or telephone expenses incurred

The accompanying staff will not be responsible for any act or omission of any medical or dental practitioner or medical officer attending or treating my child.

Signature .....

Full Name .....
(Please Print)

Date .....

Authorisation to Dispense Medication

Medications Daily and As Needed (i.e.: inhalers, allergy medications, medications taken at home).

Diagnosis ..... **Medication Name / Dose** .....

Diagnosis ..... **Medication Name / Dose** .....

Diagnosis ..... **Medication Name / Dose** .....

Additional Comments/ Information/ Medication:

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The following medications are provided by the School's Infirmary. Please be aware that non-pharmacologic interventions (ice, heat, rest) will generally be attempted first. Dosage is per manufacturers dosing instructions.

For Pain/Fever: Tylenol, Paracetamol, Panadol Yes ☐ No ☐

For Cough/Sore Throat: Cough Drops Yes ☐ No ☐

All medications must be supplied by a parent/guardian in pharmacy prescription containers, labelled with the name of the child, name of the medication, strength, dosage, frequency, doctor's name and date of original prescription.

Authorisation

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur. I authorise the teacher in charge or host family who is with my chid to consent, where it is impractical to communicate with me, and agree to my child receiving such medical treatment as is necessary, including hospitalisation, surgery, and blood transfusion and anaesthetic. I give permission for Kincoppal Rose Bay and host family to pass this information to a third party (e.g.: doctor, hospital) to facilitate the medical treatment of my child.

Signature .....

Full Name .....
(Please Print)

Date .....