COOLABUNIA STATE SCHOOL

MS 537, KINGAROY, Qld 4610

A.B.N: 40 690 029 797

Principal: Mr Murray Johnston *Phone: 4160 0333*

Email: the.principal@coolabunss.eq.edu.au *Fax: 4160 0300*

STUDENT MEDICAL RECORD

To be completed by parent/guardian of all students participating in excursion which involve an overnight stay

1. STUDENT DETAILS

Name of Student:	Date of Birth:
Excursion/Camp:	Date/s:

2. MEDICAL CONDITION

Please indicate below any known medical conditions relevant to the above-named student. In those instances where there is a "YES" response, please describe the nature of the problem or provide a letter from your doctor**.**

MEDICAL CONDITIONS	RESPONSE	ADDITIONAL COMMENTS
Heart Problems	YES/NO	
Blood Pressure	YES/NO	
Respiratory Problems (other than asthma)	YES/NO	
Asthma	YES/NO	
Epilepsy	YES/NO	
Operations	YES/NO	
Allergies	YES/NO	
Drug Reactions	YES/NO	
Recent Illness	YES/NO	
Phobia	YES/NO	
Bed-wetting	YES/NO	
Other	YES/NO	
Date of most recent tetanus injection		
Special Dietary Requirements:	YES/NO	Please specify:

3. MEDICAL PRACTITIONER

Name of Family Doctor:		
Address of Doctor		
Telephone No. of Doctor		
Medicare No.		Expiry Date:

…2/- (Please complete overleaf)

4. PRESCRIBED MEDICATIONS

The medication(s) listed below has/have been prescribed for my son/daughter by a registered practitioner and will be required to be administered while my child is involved in the excursion indicated in Section 1.

I hereby request that the teacher accompanying the excursion who has been so authorised by the Principal, to administer the medication(s) in accordance with the instructions written on the medication container(s) by the pharmacist in accordance with the practitioner's instructions.

I understand that all unused medication(s) will be returned to me.

Signature of Parent/Guardian: _____

Printed Name: _____ Date: _____/_____/_____

Please rule an oblique line through any unused spaces below.

NAME OF MEDICATION	QUANTITY OF MEDICATION	TIMES FOR ADMINISTRATION

5. DISCLAIMER

I hereby authorise the medical practitioner identified in Section 3 to provide hospital authorities or tother qualified medical practitioner(s) with additional information concerning any of the medical conditions identified in Section 2, should such need arise.

Signature of Parent/Guardian: _____

Printed Name: _____ Date; _____/_____/_____

6. AUTHORITY

I hereby authorise the supervising teachers to obtain any medical or associated assistance which they deem to be necessary should any medical condition or accident occur.

I agree to pay any medical, dental and/or pharmaceutical expenses incurred on behalf of the above student which are not covered by my personal/family medical benefits fund.

I further authorise qualified practitioners to perform surgery, administer anaesthetic and/or administer blood transfusions if such an eventuality should arise.

I understand that, should such circumstances arise, the supervising teacher will endeavour to contact me by phone **in the first instance.**

Signature of Parent/Guardian _____
Phone(s): Home: _____ Work: _____ Mobile: _____
Printed Name: _____ Date; _____/_____/_____

EMERGENCY CONTACT IF YOU HAPPEN TO BE UNAVAILABLE

Name: _____ Phone: Home: _____ Work: _____

Relationship to Child: _____ Mobile: _____