

LHD CONFIDENTIAL MEDICAL FORM

MEDICAL DETAILS

Doctor's Name: _____

Doctor's Phone No.: _____

Ambulance Subscription: Yes No

Membership No.: _____

Expiry Date: ____/____/____

Medicare No.: ____/____/____ Ref. No.: ____

Expiry Date: ____/____/____

MEDICAL HISTORY

1. Has your daughter been medically diagnosed with:

- | | | |
|-------------------|--------------------------|-----------------------|
| Asthma | <input type="checkbox"/> | |
| Anxiety Disorder | <input type="checkbox"/> | |
| Allergies | <input type="checkbox"/> | Please specify: _____ |
| Epilepsy | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | |
| Heart Condition | <input type="checkbox"/> | |
| Migraines | <input type="checkbox"/> | |
| Sight Disorder | <input type="checkbox"/> | Please specify: _____ |
| Hearing Disorder | <input type="checkbox"/> | Please specify: _____ |
| Bleeding Disorder | <input type="checkbox"/> | Please specify: _____ |
| Phobia | <input type="checkbox"/> | Please specify: _____ |
| Other | <input type="checkbox"/> | Please specify: _____ |

If you have ticked any of the boxes above please provide a Management Plan signed by your doctor.

2. Does your daughter take any medication for the condition stated above: Yes No

- | | | |
|-----------|--------------------------|--|
| Epipen | <input type="checkbox"/> | An Anaphylaxis Management Plan must be provided |
| Nebuliser | <input type="checkbox"/> | An Asthma Management Plan must be provided |
| Other | <input type="checkbox"/> | Please specify _____ |

3. Does your daughter have a diagnosed disability? Yes No

If yes, please specify: _____

4. Has your daughter had a serious injury in the last 12 months? Yes No

If yes, please specify: _____

DECLARATION/AUTHORISATION

- I/We declare that the information which I/We have provided on this form is complete and correct and that I/We will notify LHD if any changes occur.
- I/We authorise the teacher or any employee of LHD who is with my daughter, to give consent where it is impractical to communicate with me, and agree to my daughter receiving such medical or surgical treatment as may be deemed necessary.
- I/We give permission for LHD staff to pass this information to a third party (i.e. Ambulance Officer, Doctor, Hospital) to facilitate the medical treatment of my daughter.
- I/We give permission for this form to be retained noting that I can access it at any time.

Parent/Legal Guardian Name: _____ Signature: _____ Date: _____

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