# HEALTHLEARNIN& WELLBEING FORM

- x Calrossy Anglican School collects personal informatiocluding sensitive information about
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  The primary purpose of collecting this information is to enable Calrossy Anglican School to provid schooling for yor child.

### STUDENT DETAILS

Given Name		Surname				
Address		Postcode				
Date of Birth		Female	Male	Other		
Medicare Number		Expiry Date		Position on Card		
Health Care Card Numbe	r	Expiry Date				
Private Fund Name	Type of Cover		Membership Number			
Ambulance Cover						
Is the student of Aboriginal or Torres Strait Island origin?						
No	Yes, Torres Strait Islander		Yes, Aboriginal			
Child's Doctor						
Address	Posta	ode	Telephone			
Child's Dentist						
Address	Posta	ode	Telephore			
Child's Specialist/s						

### PARENT/GUARDIAN DETAILS

Parent/Guardian 1		
Name		
Address	Postode	
TelephoneHome	Business	Mobile
Email		

Health, learning and Wellbeing Form					
Parent/Guardian2					
Name					
Address	Postode				
TelephoneHome	Business	Mobile			
Email					
Emergency Contact 1 In case	of emergency, when ne	ither parent can be reached, please contact:			
Name					
Address	Postode				
TelephoneHome	Business	Mobile			
Email					
Relationship to your child					
Emergency Contact 2 In case	of emergency, when ne	ither parent can be reached, please contact:			
Name					
Address	Postode				
TelephoneHome	Business	Mobile			
Email					
Relationship to your child					
<u>SECTION-1MEDICAL HISTORY</u> IMMUNISATION					
Have you supplied a copy <b>šf</b> Z	Z]o [• u}•š CE	vš/uuµv]•š]}v ,]•š <del>]</del> t <b>6EdĢ</b> te^šš			
		Yes No			

ALLERGIES

Please describe their allergic reaction.

#### DIET

Has your child been placed on a special diet? eg. gluten free, lactose free, dairy free etc.

If yes, please give details.

#### SPORT

Please indicate your child's swimming ability.

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Can swim 25 metres

## SECTION- ZEDUCATIONAL NEEDS

Does your child have a known learning difficulty or disabilityg., behavioural, autism, intellectual, physical, health, hearing, vision or emotional?

Name of disability

Diagnosed by lease provide any further Date of Diagnosis

Please provide any further relevant details.

Yes No

No

Yes

Can swim 50 metres

#### K-12 STUDENTS

\*The following nonprescription medications are held in the Health Centernal may be dispensed by qualified staff.

Paracetamol	DryCoughMixture-Bisolvon	Aloe Vera Gel	AntifungalCream
Aspirin	ChestyCough MixtureBisolvon	Stingose	BurnAid
Nurofen	Claratyne	Bonjela Gel	Ventolin
Zaditen Eye Drops	Coloxyl With Senna	Metameucil	Ural
Naprogesic	Betadine	SM33Liquid	Phenergan
Hydrolyte	Vicks	Bactroban	Dermaid 1%
Chlorsig Drops	Chlorsig Ointment	Sunscreen	Throat Gargles
Aqua Ear Drops	Hydrogen Peroxide 3%	Hirudoid Cream	Imodium
Telfast 60mgs	Telfast 180mgs	Cerumol Ear Drops	Solosite Gel
Buscopan	Anti-Inflammatory GeVoltaren	SOOV	Vitamin C
Mylanta	Dimetapp Day And Night	Throat Lozenges	Multivitamins
Demazin	Immune Defense Vitamins		Kwells

Signature of Parent/Guardian

Date

#### MEDICAL CONSENT A ENDROLMENT AGREEMENT FORM

Formy childwhile he/she isat the School on excursion or involved in any choolactivity.

- x I acknowledge all the School medical arealth policies and shall uphold them.
- x I agree to inform the School of any changes to information contained in this form as and when necessary amendments are required.
- x I agree to keep the choolinformed, in writing, of any current court orders relating to the custody/access/residence of my child.
- x I agree that Schoolstaff may administer authorised medications to my child, with written consent.
- x I agree that Schoolstaff may administer first aidotmy child.
- x I acknowledge responsibility for notifying the School in the second in the second se
- x I give authority for the Schoolto seek urgent medical, dental, hospital and/or ambulance services for my child.
- x I understand this corest shall remain valid unless withdrawn and notified in writing to Stochool
- x I consent for the School to } v š š u Ç Z]o [• ‰ Œ À]}µ• Z}}oI• v I}Œ u health therapists.

Signature of Parent/Guardian

Date