SINGLETON HEIGHTS PUBLIC SCHOOL

**MEDICAL FORM – General 2020**

**THE INFORMATION PROVIDED ABOVE WILL BE USED TO UPDATE YOUR CHILD’S RECORDS**

CHILD’S NAME……………………………………CLASS:……………………..DATE OF BIRTH: …………………..

ADDRESS: …………………………………………………………….. HOME PHONE: ……………………………..

Is this the main address where your child resides Yes / No? If no please specify…………………………………………

…………………………………………………………………………………………………………………………………

PARENT/CAREGIVER 1………………………………………RELATIONSHIP: ……………………………………….

HOME PHONE: ………………….... MOBILE: ......................................... WORK: ………………………………………

PARENT/CAREGIVER 2………………………………………RELATIONSHIP: ……………………………………….

HOME PHONE: ………………….. MOBILE: ………………………….. WORK: …………………………………….

Please nominate two people over the age of 18 years who may be contacted in the event of an emergency if the school is unable to contact the parents/carers:

NAME: …………………………………………… RELATIONSHIP: ……………………………………………………

HOME PHONE: ……………………….. MOBILE: …………………………….

NAME: ………………………………………….. RELATIONSHIP: ……………………………………………………

HOME PHONE: ……………………… MOBILE: …………………………….

Please state your Medicare Number:………………………………..Expiry Date....................Number On Card.....................

Does your child suffer from anything at all we should know about?

(e.g. allergies, asthma, bronchitis, bed wetting, etc.) if so please include details.

………………………………………………………………………………………………………………………………….

Is your child on any form of medication: YES/NO

If so, please state what and when it is to be given (to be administered by teachers)

………………………………………………………………………………………………………………………………….

A copy of the script or packaging is required for medication to be administered. I have attached a copy YES/NO

Note: Written notification must be provided when there are changes to a child’s medication at school.

Does your child suffer from car sickness: YES/NO

If so, what treatment is usually given: …………………………………………………………………………………………

In the event of any accident or illness, I give permission for my child to receive any medical/hospital treatment (including use of ambulance) that is deemed necessary.

NAME: …………………………………… SIGNED: …………………………………………. DATE :…………………..

 Medical 2020