Updated 30 June 2016

CRS STUDENT MEDICAL PROFILE

(Student)

To ensure we provide the best care we can in a medical emergency, we need an up to date complete and accurate record of your son/daughters ***current state of health****. This form is one that we would give to paramedics if an accident or medical emergency should occur.* ***Having key medical information that is current will help ensure a better quality of health care at the time of need***

NOTE: *We take medical needs seriously and for this reason the form must be completed fully, signed and returned to the school.*

Student's Full Name: ____

Date of Birth: ______________________________

(1) Has your son/daughter had any major injuries (breaks or strains) or illness (glandular fever etc.) in the last six months? Yes / No (Please circle)

If Yes, please state the injury/illness.

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(2) To the best of your knowledge, has your child been in contact with any infectious or contagious diseases in the last four weeks? Yes /No (Please circle)

If Yes please briefly explain

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(3) Has your son/daughter been on any medication <u>during the last month?</u> Yes / No (Please circle)

If yes please state the name of the medication and the dosage.

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(4) Is your child <u>presently</u> taking tablets and/or medication? Yes / No (Please circle)

If Yes, please state the reason why, the name of the medication, the dosage including and th time to be taken.

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(5) Please tick if your child suffers (or has ever suffered), from any of the following

( ) Dizzy spells
( ) Heart condition
( ) Asthma
( ) Black outs
( ) Migraine
( ) Chronic nose bleeds
( ) Diabetes
( ) Fits of any kind
( ) Other
( ) Colour blindness
( ) Travel sickness

(6) Please tick if your child has an allergy to

( ) Penicillin ( ) Any food ( ) Any medication

( ) Sprays, plants, dust etc. ( ) Insect bites ( ) Other allergys

If Yes what special care/treatment is recommended?

____

____

(7) Last Tetanus immunisation was ______________________________

Do you give permission for your child to receive a tetanus injection if the doctor recommends it?

Yes / No (Please Circle)

(8) In the event of an accident or emergency, do you give permission for emergency medical, dental or surgical treatment as deemed fit by medical authorities present? Yes / No (Please Circle)

Parent/Caregiver'sName: ____

Signature: ________________________ **Date:** ____________________

Name of Mother ____________________ Mobile ____________________

Name of Father ____________________ Mobile ____________________

Name of Caregiver ____________________ Mobile ____________________

Home Landline ____________________ e-mail ____________________

Address: ____

____

____ Post Code: ____________________

Emergency Contact Details

(This person must be available on the actual day/s of the trip in case you are unavailable.)

Name of emergency contact person ____________________ Mobile Number ____________________

Home Number ____________________

Emergency Contact Persons Address: ____

Medical Contact Details

Name of Family Doctor ________________________ Doctors Contact Phone Number ______________

Address of Medical Center ____