Name: .....

Class: .....

Parent Signature: .....

OFFICE USE ONLY

Date Received: .....

Date Entered: .....

Mueller College

Medical Details Form

Please ensure that this form is filled out correctly and returned
to the school office prior to your child starting for the school year.

In the interests of your child's welfare we ask that you complete this form.
The information provided by you in this document will be treated as strictly confidential
and will only be shared with the relevant staff members when necessary.

The school suggests that you retain a copy of this form for your records.
Please fill out this form as completely as possible as this would assist us
in the event of a medical emergency.

Please note that any medical MANAGEMENT PLANS should be supplied
or emailed through to the School Nurses at the below email address.

Should you have any changes to your child's medical details,
please update their information via the Parent Lounge or inform the school in writing.

Mueller College
75 Morris Rd
ROTHWELL QLD 4022. AUSTRALIA.
Phone: (07) 3897 2990 Fax: (07) 3204 0404
SchoolNurse@mueller.qld.edu.au
ABN: 48 011 019 113

Student Information

*** Denotes a required field**

Family Name: _____

Given Name(s): _____

Preferred Name *: _____

Date of Birth *: _____

Religion: _____

Boarder: Yes / No (Please circle)

Medical / Other Information

Panadol Permission: Yes / No (Please circle)

Immunisation: Yes / No (Please circle)

Private Health: Yes / No (Please circle)

Private Health Co.: _____

Private Health No.: _____

Medicare No.: _____

Medicare Expiry: _____

Medical Practitioners

Doctor _____ **Phone:** _____

Psycologist _____ **Phone:** _____

Immunisations (Past 12 months)

Tetanus: Yes / No (Please circle) **Year:** _____

Swimming Ability

Please select the most accurate description of your child's swimming ability.

☐ Advanced can swim 50 metres

☐ Beginner can swim a little

☐ Intermediate can swim a few metres on own

☐ Non swimmer not confident

Other Current Medication

Medication (e.g. Multivitamins)	Method (e.g. orally)	Details

Supplementary Information

Does your child require any of the following items? If answering 'Yes' please provide your child with the necessary items.

Ventolin & Spacer: Yes / No (Please circle)

I hereby acknowledge that the information provided is accurate.

Signature of Parent / Guardian (Please circle) _____

Please print your name _____ Date ____/____/____

Appendix A: Medical Conditions

Allergy	Yes / No (Please circle)	Additional details: _____
Anaphylaxis	Yes / No (Please circle)	Supplied Management Plan?: _____ Additional Details: _____
Asthma	Yes / No (Please circle)	If 'Yes', please complete APPENDIX B: Asthma Management Plan. This form must be completed and signed by your doctor. Supplied Management Plan?: _____
Diabetic	Yes / No (Please circle)	Supplied Management Plan?: _____ MDI/Pump: _____ CGM?: _____
Drug Allergy	Yes / No (Please circle)	Additional details: _____
Epilepsy	Yes / No (Please circle)	Triggers: _____ Supplied Management Plan?: _____
Food Allergy	Yes / No (Please circle)	Additional details: _____
General Sickness	Yes / No (Please circle)	Additional details: _____
Learning Assistance	Yes / No (Please circle)	Supplied Management Plan?: _____ Behavioural Diagnosis: _____
Mental Health	Yes / No (Please circle)	Additional details: _____

Other Medical / Reg Medication	Yes / No (Please circle)	Additional details:

Physical Impairment	Yes / No (Please circle)	Additional details:

Supplementary Medical Condition Information

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Appendix B: Asthma Management Plan

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner). Parents/carers should inform the school immediately if there are any changes to the management plan. Please tick the appropriate box and print your answers clearly in the blank spaces where indicated.

Student's Name: _____ **Age:** _____

Date of Birth: _____ **Form/Class:** _____ **Gender:** _____

Emergency Contact: _____

Home Ph: _____ **Work Ph:** _____

Mobile 1: _____ **Mobile 2:** _____

Doctor Name: _____ **Phone(BH):** _____ **Mobile/Pager:** _____

Ambulance Sub: Yes / No (Please circle) **Subscriber No:** # _____ **Medicare No:** # _____

Usual signs of student's asthma	**Worsening signs**	**Triggers**
Wheezing ☐	Wheezing ☐	Exercise ☐
Tightness in chest ☐	Tightness in chest ☐	Colds/Viruses ☐
Coughing ☐	Coughing ☐	Pollens ☐
Difficulty breathing ☐	Difficulty breathing ☐	Dust ☐
Difficulty speaking ☐	Difficulty speaking ☐	Food ☐
Other:	Other:	Which Foods?
		Other Triggers:

Does your child need assistance taking their medication? **Yes / No (Please circle)**

Any other information that will assist with the asthma management of the student?
e.g. peak flow action plan, night time asthma, recent attacks (attach additional information if necessary)

What is the usual medicine regime followed?

Medication Requirements: (including preventers, symptom controllers, medication before exercise)		
Name of Medication	**Method (e.g. puffer & spacer, turbuhaler)**	**Details**

Asthma First Aid Plan

Please tick the preferred First Aid Plan

☐ Victorian Schools Asthma Policy for Emergency Treatment of an Asthma Attack:

Section 4.5.7.8 of The Department of Education Schools of the Future Reference Guide

1. Sit the student down and remain calm to reassure the student.
2. Without delay give 4 puffs of a Reliever Inhaler (Ventolin, Respolin or Bricanyl), using a spacer. Spacer technique equals 1 puff, then take 4 breaths from spacer, repeat until 4 puffs have been given.
3. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per step two.
4. If there is no improvement, call an ambulance (000) immediately and state that "a student is having an asthma attack".
5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

OR

☐ Student's Emergency Treatment (if different from above):

- In the event of an asthma attack at school, I agree to my child receiving the treatment described above.
- I authorise school staff to assist my child with taking asthma medication should they require help.
- I will notify you in writing if there are any changes to these instructions.
- Please notify me if my child regularly has asthma symptoms at school.
- Please notify me if my child has received asthma first aid.
- I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent / Guardian Signature: _____ **Date:** ____/____/____

Doctor's Signature: _____

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly Schools Program and asthma management please contact: Asthma Victoria on (03) 9326 7088 or Toll Free 1800 645 130 or visit our web site www.asthma.org.au.

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Appendix C: Social, Educational and Behavioural History

Student's Name: _____

To support your child's time at Mueller College, on Tours or whilst on Exchanges, please provide information about your child's social, educational and behavioural history that may be helpful to their carers. You may like to include some brief information on your child's social skills, ability to work in groups, preferred learning style, communication issues, friendships and any other personal challenges they may be facing.

This information will be kept in strict confidence, and will only be shared with staff members if necessary.

Parent / Guardian Signature: _____ **Date:** ____/____/____