THIS FORM IS TO BE RETURNED TO SCHOOL

PAX HILL CAMP
2020

GROVEDALE COLLEGE

CONFIDENTIAL MEDICAL REPORT FOR SCHOOL CAMPS

This report is compiled to assist us in case of any eventuality with the children. All information is held in confidence, and these forms will be destroyed after the camp.

We ask parents to note the following requests and abide by them.

1. Is you child presently taking tablets and/or other medicine? Yes ☐ No ☐
2. If yes, please give details of dose and times to be administered.

Medicine	Dosage	Time/s to be given

3. All medicines must be handed to teacher in charge prior to leaving for camp, with your child's name, the dose to be taken and when it should be taken. Please do not allow children to be in possession of any medicine whilst on the school camp. Please present to teachers in original medication packaging.

Please complete and return as soon as possible.

Students Name _____ **Homegroup** _____ **Student No** _____

Address _____ **Postcode** _____

Contact Name: _____

Contact Telephone Nos. _____ _____

After Hours **Business Hours**

Medical/Hospital Insurance Fund _____ **Member No.** _____

Medicare No. _____

Please tick if your child suffers from any of the following:

Bed Wetting ☐ Fits of any type ☐ Heart condition ☐ Dizzy Spells ☐

Sleepwalking ☐ Asthma ☐ Blackouts ☐ Migraine ☐

Travel Sickness ☐ Other _____

Allergies to:

Penicillin ☐ Any foods ☐ Drugs ☐

Others _____

What special care is recommended? _____

_____

Last Tetanus immunisation Date _____

If over ten (10) years since last immunisation, please tick if you are arranging booster before the camp ☐

Booster Date _____

Ambulance Subscription **Yes** ☐ **No** ☐ **Number** _____

Is this the first time your child has been away from home **Yes** ☐ **No** ☐

Please sign this statement required by the Ministry for all children attending school camps or excursions. I authorise the teacher in charge of the excursion/tour to consent, where impracticable to communicate with me, to the child receiving such medical or surgical treatment as may be deemed necessary.

Signed: _____ Date: _____
Parent/Guardian

SCHOOL CAMP AND EXCURSION

VICTORIAN SCHOOLS

ASTHMA UPDATE FORM

Student's name:

DOB:

Confirmed triggers:

Has the student been hospitalised due to asthma, had an acute asthma attack or worsening asthma in the last two weeks? ☐ Y ☐ N

Has the student's asthma medications changed in the last two weeks? ☐ Y ☐ N

Is the student well enough to attend camp/excursion? ☐ Y ☐ N

This form is to be completed by parents/carers of students with asthma prior to an excursion or camp. The form is to be attached to a copy of the student's Asthma Action Plan and brought with students to the camp or excursion. Please provide as much detail as possible.

OTHER MEDICAL CONDITIONS

Has the student had any other illness in the last two weeks? ☐ Y ☐ N
If YES, please provide details:

Nature of illness? _____ When? _____

Severity? _____ Has this affected their asthma? ☐ Y ☐ N

ALLERGIC RHINITIS (HAY FEVER)

Does the student hay fever? ☐ Y ☐ N Does the student have an action plan for hay fever? ☐ Y ☐ N

Confirmed Triggers for hay fever	Medication	Device	Dose	When

Treatment

ADDITIONAL ASTHMA MEDICATION REQUIREMENTS

1. Medication	Device	Dose	When

Instructions for use

2. Medication	Device	Dose	When

Instructions for use

Doctor's Name:

Phone:

Address:

Emergency Contact:

Phone:

The information provided on this plan is true and correct.

Signed:

Date:

Additional information

For asthma information and support or to speak with an Asthma Educator call **1800 ASTHMA** (1800 278 462) or visit **asthma.org.au**

ASTHMA AUSTRALIA