



Northam Residential College

STUDENT HEALTH RECORD FORM

STUDENT'S FULL NAME:

THIS FORM TO BE COMPLETED BY THE STUDENT'S PARENTS OR LEGAL GUARDIANS

CONFIDENTIAL

The information contained within this Health Record Form will only be available to college supervisory staff and the attending medical practitioner

Updated May 2007

STUDENT HEALTH RECORD FORM – CONFIDENTIAL

The following sections to be completed by student's parents or legal guardians
Please complete in BLOCK LETTERS

PERSONAL PARTICULARS

STUDENT'S FULL NAME:[male / female]

DATE OF BIRTH[day][month] [year]

FULL NAME OF PARENTS OR LEGAL GUARDIANS:

.....
[Mother's first name] [Father's first name] [LASTNAME]

IF DIVORCED, CUSTODIAL PARENT:

ADDRESS: Post Code:.....

TELEPHONE: []..... [Home] []..... [Work]

EMERGENCY CONTACT [if different from above] [].....

Person to be contacted in case of an emergency if parent/guardian unavailable:

Name: Telephone: [].....

Address: Post Code:.....

MEDICARE No: Card Reference No:..... Expiry Date.....

HEALTH CARE CARD No..... PRIVATE MEDICAL FUND: YES / NO

NAME OF FUND: FUND MEMBERSHIP No

ST JOHN AMBULANCE - YES/NO - MEMBERSHIP No:

FAMILY DOCTOR: Telephone: [].....

ADDRESS: Post Code:.....

In towns where more than one of the following health professionals are available, please indicate your preference for the following:

DOCTOR: Account YES / NO

DENTIST: Account YES / NO

CHEMIST: Account YES / NO

COUNSELLOR: Account YES / NO

MEDICAL HISTORY

IMMUNISATIONS/VACCINATIONS [please indicate year/date on which last given]:

Diphtheria/Tetanus or ADT booster		Meningococcal C vaccination	
Hepatitis B vaccination		Polio Booster	
Measles/Mumps/Rubella		Whooping Cough	
Hib		Other:	

CHILDHOOD DISEASES/ILLNESSES -please indicate by a tick if student has suffered from any of the following:

ADHD <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Glandular Fever <input type="checkbox"/>	Mumps <input type="checkbox"/>
Allergies <input type="checkbox"/>	Depression <input type="checkbox"/>	Head Injury <input type="checkbox"/>	Pneumonia <input type="checkbox"/>
Asthma (see below) <input type="checkbox"/>	Ear Problems <input type="checkbox"/>	Heart Problems <input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>
Back Injury <input type="checkbox"/>	Eczema <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Whooping Cough <input type="checkbox"/>
Bronchitis <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>	Other (specify): <input type="checkbox"/>
Chicken Pox <input type="checkbox"/>	German Measles <input type="checkbox"/>	Measles <input type="checkbox"/>	

PRESENT MEDICAL ILLNESS/ES

Is the student under regular medical attention? Is there any other information that may be useful in assisting the college to manage the student's ongoing medical support. Please give full details (on separate sheet if necessary):

.....
.....
.....

ASTHMA HISTORY

Has student been to hospital due to asthma in the past 2 years? YES* / NO
Has student been treated with oral cortisone in the past 12 months? YES* / NO

Name, dose and device used of current preventer medication.....

What signs/symptoms does student display when their asthma is getting worse?.....

Name, dose and device used of current reliever medication.....

Does student have an asthma action plan? If yes, please attach a copy

ALLERGIES - please provide details of any diagnosed allergies to the following

Medications [eg Penicillin]

Food

Other [eg plants, insect bites/stings, etc]

PRESCRIPTION MEDICATIONS

List prescription medications, their dose and frequency that student is currently taking [eg ADHD medications].....

NON-PRESCRIBED MEDICATIONS

Please specify non-prescribed medications to be administered when required [eg Panadol, Mylanta, etc]

SIGHT

Are glasses/contacts worn? YES / NO Purpose [eg reading]:

Name and Address of Eye Specialist:

TEETH

Does the student visit the dentist regularly? YES / NO Existing dental problems:

Name and address of family dentist

Do you wish the student to be seen by the town dentist in an emergency? YES / NO

Do you wish the student to be seen by the town dentist on a regular basis? YES / NO

BLOOD GROUPPos/Neg.....

Is the student a carrier of any blood borne infection [eg HIV, Hepatitis]?* YES / NO

Details:

** It is not college policy to exclude a student because he/she is a carrier or suffers from a blood borne infection. However, the college does require full information on the infection in order to manage the student's activities and to respond appropriately to any accident or emergency.*

FAMILY MEDICAL HISTORY [please specify relevant details only if appropriate]

CULTURAL/RELIGIOUS ETIQUETTE relating to medical/health care:.....

MEDICAL EXAMINATION:

It is important that college staff and the medical practitioner have access to a current medical record for each student. Parents/guardians are therefore asked to arrange a full medical examination of their child prior to entry to the college. Alternatively, parents/guardians may request an examination be arranged with the local medical practitioner of their choice during the student's first two weeks at the college by completing the section below.

I [parent/guardian] request that the

Residential College arrange a medical examination for [student's name] with

Doctor

Signature of parent/guardian:Date:.....

THIS SECTION TO BE COMPLETED BY A MEDICAL PRACTITIONER

PHYSICAL EXAMINATION:

1 GENERAL

Height Weight

General Nutrition

2 RESPIRATORY SYSTEM

Any sign of past or present disease? YES / NO

Any abnormality on examination? YES / NO

3 CARDIO-VASCULAR SYSTEM

Blood pressure

Any abnormality of heart sounds or rhythm? YES / NO

4 GASTRO INTESTINAL SYSTEM

Any abnormality of abdominal viscera? YES / NO

5 UROGENITAL

Urine S.G. Protein Sugar Testes descended

6 ENT

Any abnormality of mouth, throat or nose? YES / NO

Any abnormality of ears or hearing? YES / NO Left: Right:

7 EYES

Any abnormality on examination? YES / NO

Visual acuity Uncorrected Left: Right:

Corrected Left: Right:

Colour Vision

8 CNS

Any abnormality, eg speech problem, enuresis? YES / NO

Reflexes

9 INFECTIOUS DISEASES

Is the student a carrier of any infectious disease, eg Hepatitis B? YES / NO

Has the student been immunised against Hepatitis B? YES / NO

10 Any comments on examination findings:

.....

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Any other comments which might be useful to the college in managing the student's health care:

.....

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.....

.....

Signature: Date:

Address: