

WARRAGAMBA PUBLIC SCHOOL

Medical Information Form for Overnight Excursions – Page 1

Student Name:		Class:	
Home Telephone:		Contact No. (During Day):	
Child's Doctor:		Telephone (Doctor):	
Private Health Insurance Fund:		Member No.	
Medicare Number:			
Does your private health insurance include Ambulance Cover?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have Ambulance Cover?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

PERSONAL HISTORY – Please answer the following questions:

1. Is he/she in good health?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Does he/she suffer from any of the following:	
a. Asthma or any allergic conditions?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Skin conditions?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Epilepsy, fits or blackouts?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Diabetes?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. Adverse reactions to drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you have answered YES to any of the questions above, please give details:	

3. Does your child suffer from any chronic illness or disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you have answered YES to question 3, please give details:	

4. Has he/she suffered from any acute illness or any injury during the past four weeks?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you have answered YES to question 4, please give details:	

5. Is he/she taking any form of medication at present?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you have answered YES to question 5, please give details:	

Please Turn Over →

WARRAGAMBA PUBLIC SCHOOL

Medical Information Form for Overnight Excursions – Page 2

6. Does he/she wet the bed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Has he/she had the combined Diphtheria/Tetanus/Toxoid booster injection?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Has he/she been away from parents before?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

FOOD ALLERGIES/SPECIAL DIETARY NEEDS/TRAVEL SICKNESS

9. Does your child have any allergies to any particular types of foods/products?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you answered YES to question 9, please give details: _____ _____ _____ _____		
10. Does your child have any special dietary needs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you answered YES to question 10, please give details: _____ _____ _____ _____		
11. Does your child suffer from Travel Sickness?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you answered YES to question 11, please provide details of medication: _____		

In the event of any accident or illness, I authorise the obtaining on my behalf such medical assistance as my child may require. I also undertake to pay medical fees and/or costs of medications which may be incurred while my child is participating in this overnight excursion.

Signed: _____

Date: _____