

Year 9 Camp 2019

CONFIDENTIAL HEALTH INFORMATION

YEAR 9 STUDENT

(Return to Student Services ASAP)

| Stude | nts Name: | |
|----------------|---|----------------|
| Date of Birth: | | Male/Female |
| Addre | ss: | |
| | | |
| Paren | t/Caregiver 1 Name: | |
| Daytime Phone: | | Evening Phone: |
| Paren | t/Caregiver 2 Name: | |
| Daytime Phone: | | Evening Phone: |
| Emer | gency Contact Name: | |
| Daytime Phone: | | Evening Phone: |
| | | |
| 0 | I agree to my child receiving any emergency medical, dental or surgical treatment, including anesthetics or blood transfusion as considered necessary by the medical authorities present. | |
| 0 | Any medical costs not covered by ACC or a community service card, will be paid by me. | |
| | | |

Parent/Caregiver signature:

DO YOU HAVE?

| Asthma Yes • No • | | |
|---|--|--|
| Possible trigger/causes: | | |
| Usual treatment given during an attack: | | |
| Medication provided | | |
| What is the dosage? | | |
| Epilepsy Yes O No O | | |
| Type of seizures: | | |
| Possible triggers: | | |
| Warning signs: | | |
| Usual length of seizure: | | |
| Medication provided: | | |
| What is the dosage? | | |
| Diabetes Yes □ No □ | | |
| Signs/symptoms of low blood sugar: | | |
| Signs/symptoms of high blood sugar: | | |
| Medication provided: | | |
| What is the dosage? | | |
| GlucaGen injection to be provided by student for emergency use. | | |
| Migraine Yes · No · | | |
| Possible triggers/causes: | | |
| Warning signs/symptoms: | | |
| Medication provided: | | |
| What is the dosage? | | |

| Allergies Yes No No No No No No No N | | |
|--|--|--|
| History of anaphylactic reaction: | | |
| Triggers/causes: | | |
| Signs/symptoms: | | |
| Treatment required: | | |
| Medication provided: | | |
| What is the dosage? | | |
| EpiPen to be provided by student for emergency use if history of anaphylactic reaction | | |
| Food - will be supplying their own Yes - No - | | |
| Due to allergies, my child will be bringing their own food, with each meal bagged, named and in a chilly bin. | | |
| Comments: | | |
| | | |
| | | |
| Please give details of any illness or accident your son/daughter has had recently or in the past which may affect their participation in any activities: | | |
| | | |
| • | | |
| | | |
| | | |
| Are you taking any other medications for use? YES / NO for treatment of: | | |
| Medication provided: | | |
| What is the dosage? | | |
| | | |
| Please rank your child's swimming ability below 1 = cannot swim 10 = a very strong swimmer | | |
| 1 2 3 4 5 6 7 8 9 10 | | |