Christt Church Grammar School

Student Health Record

It is a condition of enrolment that a parent or guardian must complete and return this health record to Christ Church prior to a student entering or returning to the School. Failure to do so will result in a student's enrolment being suspended. As per the School's Privacy Policy, information detailed on this form may be given to other members of staff when deemed appropriate. In the event of an emergency, the School will make every effort to contact you or your emergency contact. However, if such contact cannot be made, the School will organise essential medical and/or dental treatment. If necessary, ambulance transport will also be arranged by the School. Costs for these arrangements remain the responsibility of the parent.

A COPY OF THE STUDENT'S CURRENT IMMUNISATION HISTORY MUST BE ATTACHED TO THIS RECORD

OFFICE USE ONLY ACADEMIC YEAR ☐ HOUSE & TUTOR ☐ YEAR OF ENTRY ☐ BOARDER ☐

PART 1 — TO BE COMPLETED FOR ALL STUDENTS

(PLEASE PRINT)

Student's Full Name GIVEN NAMES SURNAME Date of Birth

Residential Address Postcode

Mother/ Guardian GIVEN NAMES SURNAME Phone (Home)

Address (if different from student's) Postcode

Phone (Work) Mobile Email

Father/ Guardian GIVEN NAMES SURNAME Phone (Home)

Address (if different from student's) Postcode

Phone (Work) Mobile Email

Boy Resides With Both Parents ☐ Mother ☐ Father ☐ Guardian ☐

EMERGENCY CONTACT (NOT PARENT)

Please nominate a responsible adult who resides in Perth and who can be reached in an emergency, should the School not be able to contact you.

(PLEASE PRINT)

Name GIVEN NAMES SURNAME Relationship to student

Address Phone (Home)

Phone (Work) Mobile Email

MEDICATIONS

Is your son currently taking any medications on a regular basis? NO ☐ YES ☐ If yes, please complete below:

MEDICATION 1	MEDICATION 2	MEDICATION 3
Name: Dosage:	Name: Dosage:	Name: Dosage:

PARENT/GUARDIAN MEDICATION CONSENT

(PLEASE PRINT)

I, FULL NAME **DO / DO NOT** (please circle)

give my consent for the School Health Centre staff to administer over the counter medication to my son/ward as deemed necessary.

Signature Date

PARENT/GUARDIAN DECLARATION

(PLEASE PRINT)

I, FULL NAME have provided all my son's/ward's significant current and past medical history, including his full immunisation record. In addition to this, I agree to inform the Health Centre staff of any relevant changes to his health status as well as any alterations to his contact details.

Signature

ASTHMA

Does your son suffer with asthma? NO ☐ YES ☐ If yes, please complete the following:

Please indicate severity MILD ☐ MODERATE ☐ SEVERE ☐

Preventative Used

Reliever Used

What triggers an attack? (eg allergy, exercise, chest infection)

Has your son been hospitalised as a result of an acute asthma attack? NO ☐ YES ☐ Last hospitalisation date

ALLERGIES

Does your son suffer with any allergies? NO ☐ YES ☐ If yes, please complete the following:

DRUG allergy to Reaction

Treatment required

FOOD allergy to Reaction

Treatment required

OTHER allergy to Reaction

Treatment required

BEE allergy MILD ☐ MODERATE ☐ SEVERE ☐

Treatment required

Has your son been hospitalised as a result of an allergic reaction? NO ☐ YES ☐ Last hospitalisation date

If your son requires an adrenalin auto-injection device, such as an Epipen, to be administered, you MUST contact the Health Centre on 9442 1700. We will need to meet with you and your son before he enrols or returns to the School.

MEDICAL HISTORY

PLEASE USE BACK COVER IF NECESSARY

Is there any significant relevant surgical or medical condition including enuresis that restricts his activities at school? NO ☐ YES ☐ If yes, please provide details or contact Health Centre staff on 9442 1700

Mental Health

Does your son have any mental health issues of which the School should be aware? NO ☐ YES ☐ If yes, please provide details or contact Health Centre staff on 9442 1700

GENERAL INFORMATION

Please indicate if your son:

Is colour blind YES ☐ Untested ☐

Wears glasses or contact lenses YES ☐ Please Specify

Wears a hearing aid YES ☐

Wears dental braces YES ☐ Name of Orthodontist

PART 2 — FOR BOARDING STUDENTS ONLY

Student's Medicare Number ______ Position on card ______ Card Expiry Date ______

Student's Health Care Card Number ______ Card Expiry Date ______

Private Health Cover / Name of Fund ______ Number ______

Dental: Is your son currently enrolled with the Department of Health School Dental Service? Yes ☐ No ☐

Name of Dental Clinic ______

INFECTIOUS CONDITIONS

If your son develops a contagious condition or other significant medical problem he will need to leave the boarding house. If you are unable to assist your son at such a time, you must nominate a responsible adult who can collect and take care of him on your behalf.

RESPONSIBLE ADULT DETAILS

(PLEASE PRINT)

Name GIVEN NAMES ______ SURNAMES ______ Phone (Home) ______

Home Address ______ Postcode ______

Phone (Work) ______ Mobile ______ Email ______

Relationship to Student ______

TO BE COMPLETED BY MEDICAL PRACTITIONER

GENERAL OBSERVATION AND PHYSICAL EXAMINATION

Height ______ Weight ______ BP ______ Pulse ______

Please tick ONLY if an abnormality is detected		**Please comment or attach documentation** (additional space overleaf)
Ear, Nose and Throat	☐	
Respiratory System	☐	
Cardio-Vascular System	☐	
Central Nervous System	☐	
Gastrointestinal System	☐	
Musculoskeletal System	☐	
Vision/Colour Vision	☐	
Skin	☐	
Urogenital System	☐	
Urinalysis	☐	

Is there any significant relevant surgical or medical condition including enuresis that restricts his activities at school? NO ☐ YES ☐

If yes, please provide details or contact Health Centre staff on 9442 1700

______

Do you have access to the boy's full history? YES ☐ NO ☐

How long has the boy been your patient? ______

Doctor's Signature ______ Date ______

Full Name ______ Phone ______

Address ______

DOCTOR'S STAMP

PLEASE TURN OVER

FOR ADDITIONAL INFORMATION

Confidential documentation may be returned directly to the School Health Centre.

Health Centre
Christ Church Grammar School
PO Box 399, Claremont, Western Australia 6910
T: (08) 9442 1700
F: (08) 9442 1702
E: health@ccgs.wa.edu.au
W: www.ccgs.wa.edu.au

CRICOS 00433G
ABN 52 791 098 115

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