CLINIC HEALTH CHECK	
Student Name:	Date of birth: / /
Medicare card number:	Health Care Card number:
Expiry date:	Gender: Male / Female (Please circle)

AUTHORITY CONSENT TO SUPPLY MEDICAL INFORMATION	
I consent to medical information about my child being released to Wiltja Anangu Secondary College. *(This consent to share information is given for the whole period of the student's enrolment at Wiltja)*	
Guardian Name:	
Guardian Signature:	Date: / /

TO BE COMPLETED BY AUTHORISED CLINIC STAFF			
Does the student have any of the conditions below? (Please circle)			
Physical Disabilities	Yes / No	ADD or ADHD	Yes / No
Sugar Diabetes	Yes / No	Blackouts	Yes / No
Heart Problems	Yes / No	Epilepsy	Yes / No
Rheumatic Fever/RHD	Yes / No	Phobias	Yes / No
Kidney Problems	Yes / No	Travel Sickness	Yes / No
Migraines	Yes / No	Depression	Yes / No
Asthma	Yes / No	Ear Infections	Yes / No
Hearing Loss	Yes / No	Substance Abuse	Yes / No

If the the answer is yes to any of the above items, a Health Plan from a Doctor and/or Clinic must be provided prior to travel
Allergies (medication, food, bees, other):
Any severe illness, operations or medical conditions not listed:
Relevant information about condition(s):
Medications? Yes / No If YES please list here (on arrival the student must give medications to a Youth Worker):

CLINIC STAFF DETAILS	
Name:	Date:
Position:	Community / Medical Clinic: