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| **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 Secondary College. |
| Guardian Name:  |
| Guardian Signature:  | Date: |  / |  / |  |

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| **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 / NoIf YES please list here (on arrival the student must give medications to a Youth Worker): |
| **CLINIC STAFF DETAILS** |
| Name:  | Date:  |
| Position:  | Community / Medical Clinic:  |