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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 / 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: | |