



# St. Peter's Catholic School

Quality Education in a Christian Community

**This form will be taken on the event.**

## STUDENT HEALTH PROFILE

*This profile is designed to assist in the care of all participants at EOTC events. One form must be completed for EACH student.*

### Tui Ridge Camp 2019

NAME: \_\_\_\_\_

1. Please tick if your child has any of the following:

- |                     |                          |                 |                          |                  |                          |
|---------------------|--------------------------|-----------------|--------------------------|------------------|--------------------------|
| Migraine            | <input type="checkbox"/> | Epilepsy        | <input type="checkbox"/> | Asthma           | <input type="checkbox"/> |
| Diabetes            | <input type="checkbox"/> | Travel Sickness | <input type="checkbox"/> | Fits of any type | <input type="checkbox"/> |
| Chronic nose bleeds | <input type="checkbox"/> | Heart Condition | <input type="checkbox"/> | Dizzy spells     | <input type="checkbox"/> |
| Gluten Free         | <input type="checkbox"/> | Dairy Free      | <input type="checkbox"/> |                  |                          |

Other (please specify) \_\_\_\_\_

2. Is your child currently taking medication?                      Yes       No

If YES, please state: Ailment/s \_\_\_\_\_

Other treatment: \_\_\_\_\_

3. Is your child allergic to any of the following?

- |                         | Yes                      | No                       | Please specify |
|-------------------------|--------------------------|--------------------------|----------------|
| Prescription medication | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Food                    | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Insect bites/stings     | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Other allergies         | <input type="checkbox"/> | <input type="checkbox"/> | _____          |

What treatment is required? \_\_\_\_\_

4. For overnight events: Sleepwalking  Bedwetting

5. We strongly advise you to immunise your child against Tetanus prior to attending camp.

When was your/your child's last tetanus injection? \_\_\_\_\_

6. Outline any dietary requirements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. I give permission for my child to be given panadol if necessary Yes  No

8. I give permission for my child to be given phenergan if necessary. Yes  No

9. Is there any information the staff should know to ensure the physical and emotional safety of your child? (for example cultural practices; disability; anxiety about heights/darkness/small spaces; behaviour or emotional problems).

Yes  No

If YES, please state or attach the information.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I also agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration.

I will inform the school as soon as possible of any changes in the medical or other circumstances between now and the commencement of the event.

I agree to my child receiving any emergency medical, dental, or surgical treatment, including anesthetic or blood transfusion, as considered necessary by the medical authorities present.

Any medical costs not covered by ACC or a Community Service Card will be paid by me.

If my child is involved in a serious disciplinary problem, or actions that threaten the safety of others, s/he will be sent home at my expense.

Print name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*(To be completed and signed by parent/caregiver of child participant)*