Mount Evelyn Christian School
135 York Road
Mount Evelyn VIC 3796
ABN 19 775 686 269

Tel (03) 9738 6000
Fax (03) 9738 6001
office@mecs.vic.edu.au
www.mecs.vic.edu.au

2015 CONFIDENTIAL MEDICAL INFORMATION FOR SCHOOL CAMPS

This information is intended to assist the school in case of any medical emergency involving your child whilst on camp. **Please complete this form and return it immediately to your child's class teacher.**

Camp being attended: …….. **Dates of Camp:** …….

Student Name: …… **Year:**……. **Class:**…… **DOB**:……..

Parent/Custodian Names: ……

Address:……...

Home: ……**Work:** ……

Mobile: *(M=Mother F=Father)* ……..

Emergency Contact: (person who will accept responsibility if parents/guardians cannot be contacted)

……..

Home: …….. **Work:**…… **Mobile:** ……

Medical Information we should know:

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If your child suffers from any moderate to severe medical condition, please ensure that you have a management plan submitted at the school.

For mild-moderate allergic reactions, your child requires a green/blue Action Plan for Allergic Reactions.

For students at risk of anaphylaxis, your child requires a red/blue Action Plan for Anaphylaxis.

Medication: Please list any medication your child uses including dosage and times to be administered. (All medication should be placed in a clearly labelled/named plastic bag and handed to the class teacher on the morning of the camp.) ……..……..

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Tetanus immunisation: Last tetanus immunisation was …… (date/year if known)

Doctor: …….. **Medicare No:** ……..

Preferred hospital: ……

PTO

Does your child have any <u>food</u> allergies/intolerances (eg nuts/eggs)? **Yes / No**

(If YES, please ensure you have a current Allergic Reaction or Anaphylaxis Action Plan submitted to the school.)

SPECIFIC details please of what your child can/can not eat:

……..

……..

……..

Does your child have <u>dietary requirements</u> (eg vegetarian/vegan, eating disorder – NOT preferences)? **Yes / No**

SPECIFIC details please of what your child can/can not eat:

……..

……..

……..

Does your child have any <u>medical</u> allergies (eg Penicillin)? **Yes / No**

Details:

……..

……..

……..

Do you give permission for your child to be administered Panadol if necessary **Yes / No**

Details:

……
……

Do any of the following apply to your child?

- ❑ Bedwetting
- ❑ Fits of any type^
- ❑ Heart Condition
- ❑ Dizzy Spells
- ❑ Sleepwalking
- ❑ Asthma*
- ❑ Migraine/Headaches
- ❑ Blackouts
- ❑ Travel Sickness
- ❑ Separation Anxiety
- ❑ First away from home experience

(* - please ensure the school has a current asthma action plan on file)

(^ - please give full details and treatment required)

Instructions for treatment of the above:

……..

……..

……..

In case of an emergency, I hereby authorise the staff member in charge of the camp to contact the family doctor, or nearest doctor available, and arrange for any medical, ambulance or hospital services deemed necessary. I accept responsibility for any/all costs involved. **Yes / No**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date**: _____