Academic Year Entry

200….

Year of Entry

Day Girl/Boarder

Iona Presentation College
STUDENT HEALTH RECORD

Iona requires students to complete this record prior to admission to the College. Part 1 must be completed by a parent or guardian and Part II is for boarding students only. This information will be kept confidential and may only be viewed by those parties directly concerned with the student's progress. Please return the completed form along with all other admission forms. Confidential and sensitive information may be discussed directly with the College Nurse or College Psychologist.

PART I: TO BE COMPLETED BY A PARENT OR GUARDIAN FOR ALL STUDENTS

Student's Full Name _____ Date of Birth _____

Residential Address: _____

Telephone: Home _____ Work _____ Mobile _____

Student resides with: Both Parents ☐ Mother ☐ Father ☐ Guardian ☐

Student's Medicare Number _____ Position on card _____ Expiry Date _____ Private Health Cover? NO ☐ YES ☐ Name of Fund: _____

EMERGENCY CONTACT

Please list two people who can be contacted if the College is unable to contact you.

Name 1 _____ Relationship to student _____ Daytime Contact _____

Name 2 _____ Relationship to student _____ Daytime Contact _____

EMERGENCY AND MEDICATION CONSENT

In the event of an emergency the College will attempt to contact a parent/guardian or nominated person in the first instance. However, unless advised in writing to the contrary, if such contact cannot be made, the College will arrange **medical** and/or **dental** treatment or **ambulance** transport when considered necessary. Any costs incurred will be covered by parents/guardians.

If unable to be contacted I, _____ hereby authorise the College to act on my behalf as custodian of my daughter or ward whilst she is under the College's supervision.

I, _____ give my consent for the College Nurse/Boarding House staff/Camp/Excursion/Supervisor to administer schedule 2 and schedule 3 medications (over the counter medication) to my daughter as deemed necessary.

Signature of Custodial Parent: _____ Date: _____

IMMUNISATIONS

Has your daughter been fully immunised against Measles, Mumps and Rubella? MMR1 ☐ MMR2 ☐

Please circle: Tetanus / Boostrix / ADT: Date _____

PLEASE NOTIFY THE HEALTH CENTRE IF IMMUNISATION RECORD IS UPDATED.

ASTHMA

Does your daughter suffer from asthma? NO ☐ YES ☐ If yes, please complete the following

Please indicate severity: MILD ☐ MODERATE ☐ SEVERE ☐

Preventative used: _____

Reliever used: _____

Has your daughter been hospitalised as a result of an acute Asthma attack? NO ☐ YES ☐

What triggers an attack? _____ Last hospitalisation date: _____

PLEASE ENSURE YOUR DAUGHTER CARRIES HER ASTHMA MEDICATION WHILST AT SCHOOL.

MEDICATIONS

Is your daughter currently taking any medications regularly? NO ☐ YES ☐ If yes, please complete below:

MEDICATION 1	MEDICATION 2	MEDICATION 3
Name:	Name:	Name:
Dosage:	Dosage:	Dosage:

ALLERGIES

Does your daughter suffer from any allergies? NO ☐ YES ☐

ANIMAL:_____

Reaction: _____ MILD ☐ MODERATE ☐ SEVERE ☐

Treatment: _____ EpiPen? NO ☐ YES ☐

DRUG: _____

Reaction: _____ MILD ☐ MODERATE ☐ SEVERE ☐

Treatment: _____ EpiPen? NO ☐ YES ☐

FOOD: _____

Reaction: _____ MILD ☐ MODERATE ☐ SEVERE ☐

Treatment: _____ EpiPen? NO ☐ YES ☐

OTHER: _____

Reaction: _____ MILD ☐ MODERATE ☐ SEVERE ☐

Treatment: _____ EpiPen? NO ☐ YES ☐

Has your daughter been hospitalised as a result of an allergic reaction? NO ☐ YES ☐ Last Hospitalise date: ☐

IF YOUR DAUGHTER REQUIRES AN EPIPEN, PLEASE ATTACH A CURRENT ACTION PLAN SIGNED BY HER SPECIALIST.

MEDICAL HISTORY

Does you daughter suffer from any medical condition? NO ☐ YES ☐ If yes, please provide details:

_____

Has your daughter had any operations in the past? NO ☐ YES ☐ If yes, please provide details:

_____

DOCTOR'S CONTACT DETAILS

GP: Name: _____

Address: _____ Telephone: _____

SPECIALIST: Name: _____ Telephone: _____

VISION & HEARING

Does your daughter wear glasses or contact lenses? NO ☐ YES ☐

Does your daughter wear a hearing aid? NO ☐ YES ☐

DIETARY REQUIREMENTS

Does your daughter have any special dietary needs? NO ☐ YES ☐ If yes, please specify:

SWIMMING ABILITY

How far can your daughter swim in still water? Non-Swimmer ☐ 25m ☐ 50m ☐ 100m+ ☐

SPORTING RESTRICTIONS

Does your daughter have any sporting restrictions? NO ☐ YES ☐ If yes, please specify:

PSYCHO-EDUCATIONAL

Does your daughter experience any difficulties in her learning, (e.g. reading, spelling, writing, speaking or understanding language, mathematics, attention, auditory processing, fine/gross motor skills)? NO ☐ YES ☐

If yes, please indicate the main difficulties and action taken: _____

_____

_____

Has your daughter participated in any programs for gifted and talented students? NO ☐ YES ☐

If yes, please outline: _____

_____

_____

Do you have any concerns about your daughter's social skills, behaviour or emotional well-being (e.g. Depression, Anxiety, Eating Disorders, Conduct Disorders)? NO ☐ YES ☐

If yes, please outline your main concerns: _____

_____

_____

Has your daughter been under the care of an Allied Health Specialist (e.g. Psychologist, Counsellor or Clinical Psychologist, Psychiatrist, Occupational Therapist, Speech Pathologist or Paediatrician)? NO ☐ YES ☐

If yes, please outline the reason and action taken: _____

_____

_____

PLEASE ATTACH REPORTS OF ANY ASSESSMENTS AND DIRECT TO THE COLLEGE PSYCHOLOGIST.

INVOLVEMENT OF THE COLLEGE PSYCHOLOGIST

Involvement of the College Psychologist with a student may include one or more of the following: student counselling, interview with parents, interview with teacher, classroom planning, observation of student, liaison with external agencies, individual psychometric assessment and provision of a report or feedback to the school, student and parent or guardians.
I give permission for the involvement of the College Psychologist at Iona Presentation College to assist the school in planning for my daughter if required and requested by the student, parents or teaching staff.

Signature of Custodial Parent or Guardian: _____ Date: _____

PRIVACY

Iona Presentation College collects personal information, which may include sensitive information, about the student and parents or guardians. The primary purpose of this is to assist the school to optimise student learning and development. Health information about students, which may include psychological information, is sensitive information within the terms of the National Privacy Principles under the Federal Privacy Act. In reporting back to the school, the College Nurse or College Psychologist will disclose some of this sensitive information. Information collected from students is generally shared with parents or guardians. Parents or guardians may seek access to personal information held about them or their children. Students may also seek access to personal information about them. There will be occasions when access is denied where, for example, access would impact on the privacy of others, where access may breach contractual agreements or where students have provided information in confidence. If you provide the College Nurse or College Psychologist with personal information on others such as doctors, please inform them that you have disclosed this information and why.

PART 2: TO BE COMPLETED BY A MEDICAL PRACTITIONER FOR NEW BOARDERS ONLY

GENERAL OBSERVATIONS & PHYSICAL EXAMINATION

State of Nutrition & Development

Height | Weight | BP | Pulse

Does this student have any abnormality related to the following? If yes, please comment and attach documents.

	NO	YES	
Ear, Nose & Throat			
Respiratory System			
Cardio-Vascular System			
Central Nervous System			
Gastrointestinal System			
Musculoskeletal System			
Vision/Colour Vision			
Hearing			
Skin			
Urogenital System			
Urinalysis			

Is this student subject to any recurrent complaints or conditions, including enuresis? If so please specify together with effective past treatment

Should any restriction be placed on this student's activity at school?

Any other problems such as blood disorders or recent infections such as glandular fever, Ross River Virus or Chronic Fatigue Syndrome?

Do you have access to the student's full history? NO YES

How long has this student been your patient?

Doctor's Signature

Date

Full Name

Phone

Address

DOCTOR'S STAMP