



ANNUAL MEDICAL INFORMATION FORM

CHILD'S NAME: _____

ADDRESS: _____

YEAR LEVEL: _____ AGE: _____ DATE OF BIRTH: _____

HOME PHONE No. _____

MOBILE No. _____

EMERGENCY CONTACTS

1. NAME: _____ PHONE No. _____

2. NAME: _____ PHONE No. _____

DOCTOR'S NAME: _____

DOCTORS PHONE No: _____ MEDICARE No. _____

		DETAILS
Allergies / Epi-pen use	YES / NO	
Hearing Problems	YES / NO	
Sight Problems	YES / NO	
Heart Problems	YES / NO	
Respiratory Problems eg <i>Asthma</i>	YES / NO	
Travel Sickness	YES / NO	
Blood Pressure	YES / NO	
Operations	YES / NO	
Epilepsy	YES / NO	
Recent Illness	YES / NO	
Injections & when eg Tetanus	YES / NO	
Current Medication Required **	YES / NO	
Drug reactions eg Penicillin Allergy	YES / NO	
Phobias	YES / NO	
Bed Wetting	YES / NO	
Others (please state)	YES / NO	

** Current Medication should be supplied in the prescription container with a signed letter from the Parent/ Guardian stating dosage amounts and times.

Is there any medical or psychological reason to prevent your child from participating in any of the following school activities - excursions, sport or camps? YES / NO

If YES, give details: _____
