BLACKFRIARS

OSHC Service
Confidential Medical Information

Surname: _____ First name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Home Address: _____

Emergency Contact Details

☽ Parent 1 H: _____ W: _____ M: _____

☽ Parent 2 H: _____ W: _____ M: _____

Is the student covered by a private medical benefits fund as well as Medicare? ☐ YES ☐ NO

Medicare Number: _____ Medicare Expiry Date: _____

Medical/Hospital Insurance Fund: _____ Contribution No: _____

Name & Address of Family Doctor: _____

Student Medical Information

Please tick if your child suffers any of the following:

☐ Fits of any type ☐ Heart conditions ☐ Asthma ☐ Diabetes
☐ Blackouts ☐ Migraine ☐ Anxiety disorder Other: _____

Allergies to:

☐ Penicillin ☐Other drugs ☐ Any Foods: Other: _____

Agreement

- Supervising staff may take whatever action they deem necessary to ensure the safety, well-being and successful conduct of the students/children as a group and individually.
- I understand that circumstances may arise when the school bus may be unavailable, and that a hire bus may be used to transport my child to and from school.
- In the event of an accident or illness involving my child, and contact with me or the alternative contact being impossible or unsuccessful despite continued attempts, I authorise the staff member in charge to consent to whatever emergency/critical medical or surgical treatment a registered medical practitioner considers urgent and necessary. I will pay all medical and dental expenses incurred on behalf of my child. Continued attempts to inform the parent or emergency contact will be undertaken in such circumstances until contact is made.
- I have provided all information necessary for the school to plan safe and reasonable health care support for my child. This includes, if relevant, information about any activity modifications my child may require for medical reasons.
- I understand that if at any time OSHC staff considers that my child requires emergency medical/hospital/ambulance assistance, they will have the local medical/hospital/ambulance attend my child/ren. I acknowledge that I will be liable for any medical/hospital/ambulance expenses incurred in the treatment of my child/ren.
- I consent to my child's doctor or medical specialist being contacted by medical personnel in an emergency.
- The information given is accurate to the best of my knowledge.

Name of parent/caregiver completing this form

Surname: _____ First name: _____

Signed: _____ Date: _____