ENROLMENT HEALTH FORM

Enrl-Form 1E

If "Yes" is answered to any of the shaded areas on this form, school personnel will need to complete and forward a referral form to a Registered Nurse from the State Schools Nursing Service

Student Details

Name: **School:** **Date of Birth:** / /

Parent/Guardian/Carer Details

Name:

Address:

Email Address:

Contact Numbers: (Home) (Work) (Mobile)

Student Medical Details

Medical Diagnosis/Conditions:

Emergency Contact

Name: **Phone Number(s):**

Does your child have or require any of the following:

Medical Condition/Requirement	Yes	No	Comment and Provide Details (if answered 'Yes')
Administration of Oxygen			Medical prescription required and cylinders provided from home
Anaphylaxis or Allergies			Complete a *Request to Administer Medication* form and provide an *Anaphylaxis Plan* completed by specialist or GP
Asthma			Complete a *Request to Administer Medication* form and provide an *Asthma Plan* completed by specialist or GP
Behavioural Difficulties or Concerns			
Colostomy/Ileostomy			
Communication Limitations or Aides			
Diabetes			
Epilepsy and/or Seizures (including Absences)			My child has had seizures in the last 2 years ☐ My child has emergency medication (eg midazolam) ☐
Emergency Medications			Complete a *Request to Administer Medication* form
Fears or Phobias			
Gastrostomy Tube/Button			
Heart or Blood Pressure Problems/Conditions			
Mobility Aides or Assistance (eg. wheelchair, splints etc)			
Naso-Gastric Tube			
Shunt			
Special Dietary Requirements or Eating/Drinking Difficulties			
Suctioning of Airways			
Tracheostomy			
Travel Sickness			
Urinary Catheterisation or Continence Issues/Problems			
Vision or Hearing Impairment			
Other (eg. Recent/Major Surgery)			

Privacy Notice

The Department of Education, Training and Employment (DETE) will only record, use and disclose the personal information of a student in accordance with Section 426 of the Education (General Provisions) Act 2006. The information will only be accessed by authorised departmental employees and will not be disclosed other than in accordance with this Act

Form last updated: Jan 2015

Interpreter

Queensland Government

Emergency Health Plans

Does your child currently have an Emergency Health Plan for any health condition(s)?

☐ **No** ☐ **Yes (Provide details, and forward a copy of any current Plans to the school)**

Please Specify Type of Plan: _____

Specialised Health Procedures

Does your child require assistance with any Specialised Health Procedures while at school?

☐ **No** ☐ **Yes (Provide details, and forward a copy of any current Procedure and Plans to the school)**

Please Specify Type of Procedure: _____

Medications

Please provide details of **all** medications your child is currently taking **at home and school** (including prescribed, over-the-counter, naturopathic, homeopathic, occasional and emergency medications eg midazolam, epipen, glucagon etc).

*A **Request to Administer Medication** form must be completed for any medications that need to be administered by school staff during school hours*

Name of Medication	Reason for Use	Time(s) Taken (eg 11am)	Name of Medication	Reason for Use	Time(s) Taken (eg 11am)

Health Service Providers Contact Details

Name of Health Provider		Contact Details
Hospital of Choice:		
Family Doctor (GP):		
Paediatrician:		
Neurologist/Neurosurgeon:		
Gastroenterologist:		
Pharmacist:		
Physiotherapist:		
Occupational Therapist:		
Speech Therapist:		
Others:		

Parent/Carer/Guardian Name: _____

Signature: _____ **Date:** _____/_____/_____

State Schools Registered Nurse Use Only

Actions/Comments: ……

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Name: …… **Signature:** …… **Date:** ……. / ……. / …….

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