PENINSULA
GRAMMAR

INTERNATIONAL STUDENTS
MEDICAL INFORMATION | 2018

PENINSULA

GRAMMAR

INTERNATIONAL STUDENTS

MEDICAL HISTORY
CONSENT TO MEDICAL ATTENTION
MEDICATION CONSENT FORM

THE INFORMATION RECORDED ON THIS FORM WILL BE TREATED IN THE STRICTEST CONFIDENCE AND IS INTENDED FOR SCHOOL HEALTH CENTRE STAFF AND TEACHER USE ONLY.

Copy to Central Data, School Health Centre

ENROLMENT INFORMATION

CAREGIVER 1

Title Name

Address

City/Suburb

State/Postcode

Country

Tel. Home

Tel. Work

Mobile

Email

Relationship to Student

CAREGIVER 2

Title Name

Address

City/Suburb

State/Postcode

Country

Tel. Home

Tel. Work

Mobile

Email

Relationship to Student

Please complete the following to the best of your knowledge. Not all questions will apply to all students, so please provide responses to those questions you believe are appropriate to you and your child.

DETAILS OF STUDENT APPLYING FOR ENROLMENT

Year level

Year of commencement

Student's first name/s

Student's preferred name

Student's family name

Gender ☐ Male ☐ Female

Date of birth *(please attach copy of birth certificate)*

Language/s spoken at home

Student currently resides with

(if shared custody, please provide details below, including copies of any applicable court orders)

Does the student live with both Caregivers at the same address? ☐ Yes ☐ No

If not, please provide full details of arrangements regarding custody of, or access to, the Student, including copies of any applicable court orders or legal documentation.

MEDICAL HISTORY OF INTERNATIONAL STUDENTS

It is essential for the proper medical care of your child that all these questions are answered fully and accurately, if necessary following consultation with your own doctor.

Peninsula Grammar will not enrol any student whose parents/caregivers fail to provide a complete medical history. It is also a condition of entry to the School that all students must be fully immunised. Students not already immunised should have this done prior to arrival and provide appropriate documentation to support this. Alternatively, parents should give permission for the School to immunise the student upon arrival. International students will be given an annual influenza vaccination.

Name of family doctor

Doctors' Address

Telephone

Fax

EMERGENCY CONTACT *(If parents are unavailable)*

Name

Relation to student *(Friend/Guardian/Uncle etc)*

Telephone

Mobile/cellphone

Address

HAS YOUR CHILD BEEN IMMUNISED AGAINST THE FOLLOWING DISEASES? *(Please tick)*

Diphtheria	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Tetanus	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Whooping Cough (Pertussis)	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Polio	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Measles	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Mumps	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
German Measles (Rubella)	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Meningococcal A, C, W, Y	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Meningococcal C	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Meningococcal B	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Chicken Pox	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Tuberculosis (BCG)	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Influenza	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Hepatitis A	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Hepatitis B	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No
Human Papilloma virus *(3 dates required)*	☐ Yes	Date given _____	Date given _____	Date given _____	☐ No

Please provide all immunisation certificates / information and any other relevant documentation. These certificates are usually held by your local doctor or hospital. In some circumstances the School may exclude a student who is not fully immunised or for whom an immunisation certificate has not been provided.

The School will not enrol any student whose parents/caregivers fail to provide a complete medical history and their consent for the student to be subject to the School's Immunisation Policy. The Immunisation Policy is:

1. School Health staff, as directed by the School Doctor and Health authorities, will determine those diseases against which, international students need to be immunised.

2. These may be updated at any time as required by medical circumstances at the discretion of School Health Staff as directed by the School Doctor and Health authorities.

5. Immunisations and judgements about their timing and possible combinations will be made by a Registered Medical Practitioner.

DOES YOUR CHILD SUFFER FROM A LIFE THREATENING ALLERGY - ANAPHYLAXIS?

☐ Yes ☐ No

If so, your Doctor must complete and sign the attached Action Plan for Anaphylaxis. The Action Plan must have an up to date photograph of your child.

DOES YOUR CHILD HAVE ANY NON-LIFE THREATENING ALLERGIES, SUCH AS:

Medication (e.g. Penicillin)	☐ Yes	Details _____	☐ No
Foods (e.g.eggs, nuts, seafood)	☐ Yes	Details _____	☐ No
Allergic Rhinitis (Hayfever)	☐ Yes	Details _____	☐ No
Other	☐ Yes	Details _____	☐ No

If so, your Doctor must complete and sign the attached Action Plan for Allergic Reactions and/or the Action Plan for Allergic Rhinitis. An updated Action Plan must be provided to the School Health Centre.

Does your child have any diagnosed food intolerances? If so, please list and indicate signs or symptoms and treatment.

Does your child have any health issues or diagnosed conditions? If so, please provide all relevant information, including copies of any reports.

HAS YOUR CHILD BEEN DIAGNOSED WITH ASTHMA? ☐ Yes ☐ No

If so, your Doctor must complete and sign the attached Action Plan for Asthma. An updated Action Plan must be provided ANNUALLY to the School Health Centre.

HAS YOUR CHILD HAD ANY MAJOR OPERATIONS OR SERIOUS ACCIDENTS? *(Please tick)*

Does your child wear glasses or contact lenses? ☐ Yes ☐ No

If so, when were his/her eyes last tested? _____ Date

When was your child last examined by a dentist? _____ Date

SPECIAL NEEDS

Do you have any concerns regarding your child's development *(e.g speech, hearing, physical, emotional, etc)***?** Please provide details.

Has your child received any literacy or numeracy support, been referred to any specialist services or therapists in the past *(e.g. School Counsellor, Psychologist, Occupational Therapist etc.)***?**

Please provide details and copies of any relevant reports. Please be aware of your obligation to keep the School fully informed about any issues in relation to the student of which you are, or subsequently become, aware which may relate to the intellectual, physical or social development of, or the School's ability to educate, the student. This includes any disability, physical or intellectual impairement, mental illness, psychological issue or relevant family circumstances.

Is there any information about your child's background of which the School should be aware *(e.g. Relevant family history, social difficulties, problems at previous schools, Special Ed. support etc)***?**

Notes:

If your child requires specific medication, please complete the 'Medication Consent Form'.

Medication must be provided by you for your child's individual use.

All medications accompanying students, must be clearly labelled and **translated into English**.

All medications must be submitted to the School Nurse and will be administered under their guidance.

Please attach any other information relevant to your child's medical condition and history to this form.

IS YOUR CHILD TAKING ANY REGULAR MEDICATION FOR A SPECIFIC CONDITION?

If so please complete and sign the following Medication Consent Form.

MEDICATION CONSENT FORM

Child's medical condition

Name of medication

Date medication commenced

Dosage

Frequency

Time of day to be administered

Date medication is to be ceased

I authorise staff to dispense the supplied medication as set out in this Medication Consent Form to the Student at the prescribed times.

Parent/Caregiver name

Parent/Caregiver signature Date

All medication accompanying students must be clearly labelled and within its original, unopened packaging, or in the packaging or container in which the Pharmacist dispensed it.

All medications must be supplied to the School Nurses and will be administered under their guidance.

SCHOOL NURSE MEDICATION DECLARATION

The medication prescribed above has been sighted by the School Nurse in the packaging/container in which the Pharmacist dispensed it.

Original container sighted by

School Nurse signature Date

DECLARATION AND MEDICAL CONSENT FORM FOR:

Student's name | Date of Birth

1. I hereby declare that all details given in this form are correct.	☐ Yes	☐ No
2. I consent to my child, as per the Immunisation Policy having immunisations as required and at my cost.	☐ Yes	☐ No
3. I authorise the School Health Centre Staff or Peninsula Grammar staff member to consent to medical, surgical or dental treatment or ambulance transport as may be deemed necessary, at my expense, if it is impracticable for prior communication with me or the emergency contact listed in this form.	☐ Yes	☐ No
4. I authorise School Health Centre Staff to administer over-the-counter medications such as Paracetamol, antihistamines, or general cold remedies if they deem necessary, including S2 analgesics.	☐ Yes	☐ No

Parent/Caregiver name

Parent/Caregiver signature | Date

This form should be returned to the School together with all relevant documentation immediately.

Please attach all information relevant to your child's medical condition and history to this form.

In the interests of your child's safety and wellbeing, it is essential that you advise the School immediately should any of these details change in future, or if any medical or other condition arises which affects your child.

It is a pre-condition to your child's enrolment that this form should be completed, signed and returned to the School together with other relevant enrolment documentation before your child commences at the School.

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www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For EpiPen® adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by medical or nurse practitioner:

_____

I hereby authorise medications specified on this plan to be administered according to the plan

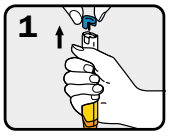
Signed:

_____

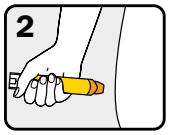
Date: _____

Action Plan due for review: _____

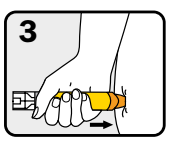
How to give EpiPen®



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



Hold leg still and PLACE ORANGE END against outer mid-thigh (with or without clothing)



PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds

REMOVE EpiPen®

All EpiPen®s should be held in place for 3 seconds regardless of instructions on device label

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy - freeze dry tick and allow to drop off
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr adrenaline autoinjector
- Give other medications (if prescribed).....
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

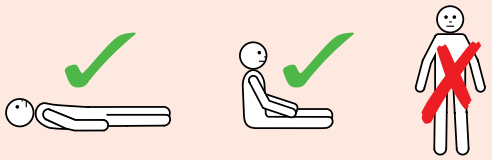
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult/noisy breathing**
- **Swelling of tongue**
- **Swelling/tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking and/or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk

- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**



2 Give EpiPen® or EpiPen® Jr adrenaline autoinjector

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline doses may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

If in doubt give adrenaline autoinjector

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS give adrenaline autoinjector FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

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ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by medical or nurse practitioner:

_____

I hereby authorise medications specified on this plan to be administered according to the plan

Signed:

_____

Date: _____

Action Plan due for review: _____

Note: This ASCIA Action Plan for Allergic Reactions is for people with mild to moderate allergies, who need to avoid certain allergens

For people with severe allergies (and at risk of anaphylaxis) there are ASCIA Action Plans for Anaphylaxis, which include adrenaline (epinephrine) autoinjector instructions

Instructions are also on the device label

Note: All EpiPen®s should be held in place for 3 seconds regardless of instructions on device label

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy - freeze dry tick and allow to drop off
- Stay with person and call for help
- Give other medications (if prescribed).....
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

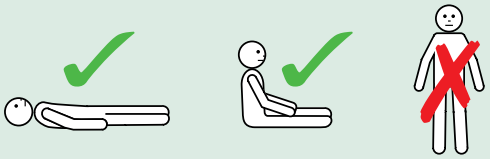
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult/noisy breathing**
- **Swelling of tongue**
- **Swelling/tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking and/or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk

- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**



2 Give adrenaline (epinephrine) autoinjector if available

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Transfer person to hospital for at least 4 hours of observation

If in doubt give adrenaline autoinjector

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS give adrenaline autoinjector FIRST if available, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

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TREATMENT PLAN
Allergic Rhinitis (Hay Fever)

Patient name: _____ **Date:** _____

Plan prepared by: _____ **Signed:** _____

ALLERGEN MINIMISATION

☐ Minimising exposure to confirmed allergen/s may assist to reduce symptoms in some people.
For information go to **www.allergy.org.au/patients/allergy-treatment/allergen-minimisation**

THUNDERSTORM ASTHMA

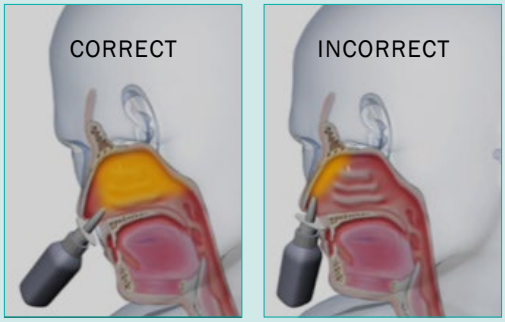
☐ If pollen allergic, try to stay indoors during thunderstorms in pollen seasons. Use preventer treatments (e.g. intranasal corticosteroid sprays or combined intranasal/antihistamine sprays). Consider allergen immunotherapy (see below). If you also have asthma, use asthma preventers regularly.
For information go to **www.allergy.org.au/patients/asthma-and-allergy/thunderstorm-asthma**

MEDICATIONS

☐ **Intranasal corticosteroid spray:** _____
☐ 1 or ☐ 2 times/day/nostril for _____ weeks or _____ months or ☐ continuous
☐ Additional instructions: _____
or
☐ **Combined intranasal corticosteroid/antihistamine spray:** _____
☐ 1 or ☐ 2 times/day/nostril for _____ weeks or _____ months or ☐ continuous
☐ Additional instructions: _____

Note:
- It is important to use these sprays correctly – see instructions below and directions for use.
- Onset of benefit may take days, so these sprays must be used regularly and do not have to be stopped every few weeks.
- If significant pain or bleeding occurs contact your doctor.
- Some treatments mentioned above require a prescription.

1. Prime the spray device according to manufacturer's instructions (for the first time or after a period of non-use).
2. Shake the bottle before each use.
3. Blow nose before spraying if blocked by mucus.
4. Tilt head slightly forward and gently insert nozzle into nostril. Use right hand for left nostril (and left hand for right nostril).
5. Aim the nozzle away from the middle of the nose and direct nozzle into the nasal passage (not upwards towards tip of nose, but in line with the roof of the mouth).
6. Avoid sniffing hard during or after spraying.



☐ **Oral non-sedating antihistamine tablet:** _____ Dose _____ mL/mg ☐ 1 or ☐ 2 times/day; or
☐ as needed ☐ Additional instructions: _____

☐ **Intranasal antihistamine sprays:** _____ ☐ 1 or ☐ 2 times/day or ☒ as needed
☐ Additional instructions: _____

☐ **Saline nasal** ☐ **spray or** ☐ **irrigation** _____ ☐ _____ times/day or ☐ as needed
☐ Use 10 minutes prior if used in conjunction with intranasal corticosteroid spray

☐ **Decongestant:** _____ ☐ nasal spray _____ times/day or ☐ tablet
Dose _____ tablets _____ times/day for up to 3 days (not more than 1 course/month)

☐ **Other medications:** _____

ALLERGEN IMMUNOTHERAPY

If allergen immunotherapy has been initiated by a clinical immunology/allergy specialist, it is important to follow the treatment as prescribed. Contact your doctor if you have any questions or concerns. For information go to **www.allergy.org.au/patients/allergy-treatment/immunotherapy**

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Asthma care plan for education and care services

Photo of student (optional)

Plan date
____/____/201___

Review date
____/____/201___

CONFIDENTIAL: Staff are trained in asthma first aid (see overleaf) and can provide routine asthma medication as authorised in this care plan by the treating doctor. Please advise staff in writing of any changes to this plan.

To be completed by the treating doctor and parent/guardian, for supervising staff and emergency medical personnel.

PLEASE PRINT CLEARLY

Student's name Date of birth

Managing an asthma attack

Staff are trained in asthma first aid (see overleaf). Please write down anything different this student might need if they have an asthma attack:

Daily asthma management

This student's usual asthma signs

- ☐ Cough
- ☐ Wheeze
- ☐ Difficulty breathing
- ☐ Other (please describe)

Frequency and severity

- ☐ Daily/most days
- ☐ Frequently (more than 5 x per year)
- ☐ Occasionally (less than 5 x per year)
- ☐ Other (please describe)

Known triggers for this student's asthma (eg exercise, colds/flu, smoke) — please detail:*

Does this student usually tell an adult if s/he is having trouble breathing?	☐ **Yes**	☐ **No**
Does this student need help to take asthma medication?	☐ **Yes**	☐ **No**
Does this student use a mask with a spacer?	☐ **Yes**	☐ **No**
*Does this student need a blue reliever puffer medication before exercise?	☐ **Yes**	☐ **No**

Medication plan

If this student needs asthma medication, please detail below and make sure the medication and spacer/mask are supplied to staff.

Name of medication and colour	*Dose/number of puffs*	*Time required*

Doctor

Name of doctor

Address

Phone

Signature Date

Parent/Guardian

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.

Signature Date

Name

Emergency contact information

Contact name

Phone

Mobile

Email

Date of approval: December 2016 | Approved by: CEO Asthma Australia | Date of review: July 2018 | AACPED2016 Care Plan for Ed-Care-Serv A4.indd | 07 March 2017

Asthma First Aid

1 Sit the person upright

- Be calm and reassuring
- Do not leave them alone

2 Give 4 separate puffs of blue/grey reliever puffer

- **Shake** puffer
- Put **1 puff** into spacer
- Take **4 breaths** from spacer

Repeat until **4 puffs** have been taken

Remember: Shake, 1 puff, 4 breaths

OR give 2 separate doses of a Bricanyl inhaler (age 6 & over) or a Symbicort inhaler (over 12)

3 Wait 4 minutes

- If there is no improvement, give **4 more separate puffs of blue/grey reliever** as above

OR give 1 more dose of Bricanyl or Symbicort inhaler

4 If there is still no improvement call emergency assistance - Dial Triple Zero (000)

- Say 'ambulance' and that someone is having an asthma attack
- Keep giving **4 separate puffs** every **4 minutes** until emergency assistance arrives

OR give 1 dose of a Bricanyl or Symbicort every 4 minutes - up to 3 more doses of Symbicort

Call emergency assistance immediately - Dial Triple Zero (000)

- If the person is not breathing
- If the person's asthma suddenly becomes worse or is not improving
- If the person is having an asthma attack and a reliever is not available
- If you are not sure if it's asthma
- If the person is known to have Anaphylaxis - follow their Anaphylaxis Action Plan, then give Asthma First Aid

Blue/grey reliever medication is unlikely to harm, even if the person does not have asthma

Asthma Australia

Contact your local Asthma Foundation

1800 ASTHMA Helpline (1800 278 462) **asthmaaustralia.org.au**

Translating and Interpreting Service

PED2016 Care Plan for Ed-Care-Serv A4.indd | 07 March 2017

THE INFORMATION RECORDED ON THIS FORM WILL BE TREATED IN THE STRICTEST CONFIDENCE AND IS INTENDED FOR SCHOOL HEALTH CENTRE STAFF AND TEACHER USE ONLY.

Copy to Central Data, School Health Centre

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GRAMMAR

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