NEW STUDENT MEDICAL DETAILS FORM

Please ensure this form is filled out correctly and returned to Junior Campus Reception before commencement.

Prince of Peace Lutheran College
20 Rogers Parade West
Everton Park QLD 4053

In the interests of your child's welfare we ask that you complete this form. The information provided by you in this document will be treated as strictly confidential and will only be shared with the relevant staff members when necessary.

The College suggests that you retain a copy of this form for your records. Please fill out this form as completely as possible as this would assist us in the event of a medical emergency. Should you have any changes to your child's details, please inform the school in writing.

Student name: _____

Year of entry: _____

Campus: ☐ JUNIOR CAMPUS (KINDY- YR 6)

☐ MIDDLE AND SENIOR CAMPUS (YR 7 – YR 12)

I hereby acknowledge that the information provided is accurate.

Signature of Parent/Guardian _____

Please print your name _____

Date _____/_____/_____

Student Information

Family Name:	
Given Names:	
Preferred Name:	
Religion:	
Date of Birth:	
Address:	
Suburb:	
State:	
Post Code:	
Home Phone:	
Mobile Phone:	
Work Phone:	
Parent/Caregiver's Name:	
Parent/Caregiver's Name:	
Email Address:	

Emergency Contact Details

An Emergency Contact is the person(s) to be contacted in the event of a Medical Emergency should we not be able to contact you. Please provide both home and mobile numbers where applicable.

Contact 1:

Full Name:
Contact Details
Relationship to Student:

Contact 2:

Full Name:
Contact Details:
Relationship to Student:

Medical Practitioners

Doctor:
Dentist:
Specialist:
Medicare Number:
Private Health Fund:

Medical Illness/Allergies

Does your child suffer from any serious illness?

YES ☐ NO ☐

Does your child suffer from any allergies?

YES ☐ NO ☐

(If yes, please give details below).

Description of illness/allergies

Treatment/Medication

I have attached a copy of my child's Anaphylaxis Action Plan.

YES ☐ NO ☐

Asthma

Does your child suffer from Asthma?

YES ☐ NO ☐

I have attached a copy of my child's Asthma Management Plan.

YES ☐ NO ☐

Please provide any other relevant information you may feel will assist us with your child.

_____

_____

_____

_____

_____

_____

_____

_____

Parent/ Caregiver Name

_____

Parent/ Caregiver Signature

_____

Date