DYNAMITE™
STUDIOS

MEDICAL INFORMATION FORM

STUDENT DETAILS

FIRST NAME		LAST NAME	
DEPARTMENT			
DATE OF BIRTH			

MEDICAL PRACTITIONERS

DOCTOR		PHONE	
GENERAL PRACTICE		PHONE	
SPECIALIST		PHONE	

CURRENT MEDICATION

MEDICATION	DETAILS

SUPPLEMENTARY INFORMATION

Does your child require any of the following items? If answering 'Yes', please provide your child with the necessary items.

ASTHMA MED.		DIABETES PACK	
EPIPEN		HEALTH PLAN	
HEARING AIDS			

I hereby acknowledge that the information provided is accurate.

Signature of Parent/Guardian: _____ **Date**: _____ / _____ / _____

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APPENDIX A: MEDICAL CONDITIONS		
ADD/ADHD	YES / NO	MEDICATION:
ALLERGIES	YES / NO	DETAILS:
ANAPHYLAXIS	YES / NO	DETAILS:
ASTHMA	YES / NO	IF 'YES' PLEASE COMPLETE APPENDIX B: ASTHMA MANAGEMENT PLAN. THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR CHILD'S DOCTOR.
BEHAVIOUR/ LEARNING CONDITION	YES / NO	DETAILS:
CARDIAC/ HEART CONDITIONS	YES / NO	DETAILS:
DIABETES	YES / NO	DETAILS:
ECZEMA	YES / NO	DETAILS:
EPILEPSY/SEIZURES	YES / NO	DETAILS:
FOOD TOLERANCE	YES / NO	DETAILS:

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HAYFEVER	YES / NO	DETAILS:
HEADACHE	YES / NO	DETAILS:
HEARING	YES / NO	DETAILS:
OTHER CONDITIONS	YES / NO	DETAILS:
RECENT INJURY	YES / NO	DETAILS:
RECENT OPERATION	YES / NO	DETAILS:
TRAVEL SICKNESS	YES / NO	DETAILS:
VISION	YES / NO	DETAILS:

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APPENDIX B: ASTHMA ACTION PLAN

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner). Parents/carers should inform Dynamite immediately if there are any changes to the management plan. Please tick the appropriate box and print your answers clearly in the spaces where indicated.

PERSONAL INFORMATION			
STUDENT NAME		AGE	
DATE OF BIRTH		GENDER	
EMERGENCY CONTACT			
HOME PHONE		MOBILE PHONE	

MEDICAL INFORMATION			
DOCTOR NAME		PHONE	
AMBULANCE SUB.	YES / NO	SUBSCRIBER NO.	
MEDICARE NO.			

USUAL SIGNS OF STUDENTS' ASTHMA	WORSENING SIGNS	TRIGGERS
☐ WHEEZING ☐ TIGHTNESS IN CHEST ☐ COUGHING ☐ DIFFICULTY BREATHING ☐ DIFFICULTY SPEAKING ☐ OTHER (PLEASE SPECIFY)	☐ WHEEZING ☐ TIGHTNESS IN CHEST ☐ COUGHING ☐ DIFFICULTY BREATHING ☐ DIFFICULTY SPEAKING ☐ OTHER (PLEASE SPECIFY)	☐ EXERCISE ☐ COLDS/VIRUSES ☐ POLLENS ☐ DUST ☐ FOOD ☐ OTHER (PLEASE SPECIFY)

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ASTHMA MEDICATION REQUIREMENTS		
NAME OF MEDICATION	METHOD	DETAILS

STUDENT'S TREATMENT PLAN

In the event of an asthma attack, I agree to my child receiving the treatment described above.
I authorise school staff to assist my child with taking asthma medication should they require help.
I will notify you in writing if there are any changes to these instructions.
Please notify me if my child regularly has asthma symptoms at school.
Please notify me if my child has received asthma first aid.
I also agree to pay all expenses incurred for any medical treatment deemed necessary.

PARENT / GUARDIAN SIGNATURE	**SIGNATURE:**	**DATE**:
DOCTOR'S SIGNATURE	**SIGNATURE:**	**DATE**: