Student Medical Form Confidential

The purpose of this form is to help us prepare for your child's program. This information is confidential and students will not normally be excluded for medical reasons.

SCHOOL: _____ **Form/Class:** _____

STUDENT'S NAME: _____ **D.O.B:** ___/___/_____ **Male □ Female □**

Parent or Guardian – Primary Emergency Contact:

Name: _____ **Relationship:** _____

Phone: (Home): _____ (Work): _____ (Mobile): _____

Medicare No: _____ **Line #:**____ **Valid to:** _____			**Doctor's Name:** _____ **Telephone:** _____
MEDICAL HISTORY	Tick **Yes or No** to all Questions		**Additional information***: Details regarding; seriousness, location, date, level of recovery, self-management strategies, required support*
Asthma	[ ] No	[ ] Yes	If YES, complete the **"Asthma Management Form"**
Allergies	[ ] No	[ ] Yes	If YES, complete the **"Allergenic Reaction Management Form"**
Diabetes	[ ] No	[ ] Yes	If YES, attach current management/care plan. A **Fitness to Participate** form signed by treating doctor will also be required.
Epilepsy	[ ] No	[ ] Yes	If YES, a **Fitness to Participate** form signed by treating doctor will also be required.
Joint/Muscle/Skeletal issues?	[ ] No	[ ] Yes	
Sight/Hearing impairment	[ ] No	[ ] Yes	
Any serious injuries/illness in the last 12 months?	[ ] No	[ ] Yes	*Date and Nature of injury/Illness*
Is your child currently on any medications?	[ ] No	[ ] Yes	*Name of medication, dosage and requirements (e.g. with food, AM or PM)*
Other: medical condition(s) that may affect participation?	[ ] No	[ ] Yes	*Any physical health issue(s) that require attention or specific support*
Other: learning, psychological, emotional or behavioural issues?	[ ] No	[ ] Yes	*Any concern(s) that require attention or specific support (e.g. management strategies for a successful experience)*
DIETARY Any special requirements?	[ ] No	[ ] Yes	*Details to assist in menu planning (e.g. vegetarian, will eat fish; gluten-free, separate stove)*

SWIMMING ABILITY My child can swim 50 metres	[ ] No	[ ] with a struggle	[ ] Comfortably	[ ] Strongly

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur. I authorise the teacher or any employee of the B Firm who is with my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for B Firm to pass this information to a third party (e.g. Doctor, Hospital) to facilitate the medical treatment of my child. I give permission for B Firm to retain this form for statutory archival requirements.

Name: _____ **Signed:** _____ **(Parent/Guardian) Date:** _____

Photograph Consent: I consent to my child being photographed and/or visual images of my child being taken during activities, for use in B Firm publications, on the B Firm website, or for publicity purposes without acknowledgment and without being entitled to any remuneration or compensation. *(Strike out this sentence if you do not consent)*

Student Evaluation Consent: I give consent for my child to complete the pre and post program course evaluation survey as part of the B Firm continuous improvement process. *(Strike out this sentence if you do not consent)*

Asthma Management Form Confidential

Participant's Name:

Name of doctor treating the participant for this condition:

Doctor's Contact Phone Number:

1) **USUAL ASTHMA ACTION PLAN**

Usual signs of participant's asthma:

☐ Wheeze ☐ Tight Chest ☐ Cough ☐ Difficulty breathing ☐ Difficulty talking ☐ Other_____

Signs participant's asthma is getting worse:

☐ Wheeze ☐ Tight Chest ☐ Cough ☐ Difficulty breathing ☐ Difficulty talking ☐ Other_____

Participant's Asthma Triggers:

☐ Cold/flu ☐ Exercise ☐ Smoke ☐ Pollens ☐ Dust ☐ Other (please describe)_____

ASTHMA MEDICATION REQUIREMENTS (Including relievers, preventers, symptom controllers, combination)

Name of Medication (e.g. Ventolin, Flixotide)	**Method (e.g. puffer and spacer, turbuhaler)**	**When and how much? (e.g. one puff in morning and night, before exercise)**

Does the participant need assistance taking their medication? Yes No If yes, how? _____

Any other information that will assist with the asthma management of the participant while on camp
(e.g. peak expiratory flow, night time asthma or recent attacks)

_____

_____

_____

_____

2) **ASTHMA FIRST AID PLAN** (Please tick preferred Asthma First Aid Plan)

☐ **School Asthma Policy for Asthma First Aid**

Step 1 Sit the person upright
- Be calm and reassuring
- Do not leave them alone.

Step 2 Give medication
- Shake the blue reliever puffer
- Use a spacer if you have one
- Give 4 separate puffs into a spacer
- Take 4 breaths from the spacer after each puff

*You can use a Bricanyl Turbuhaler if you do not have access to a puffer and spacer.
Giving blue reliever medication to someone who doesn't have asthma is unlikely to harm them.

Step 3 Wait 4 minutes
- If there is no improvement, repeat step 2.

Step 4 If there is <u>still</u> no improvement call emergency assistance **(DIAL 000).**
- Tell the operator the person is having an asthma attack
- Keep giving 4 puffs every 4 minutes while you wait for emergency assistance

Call emergency assistance immediately (DIAL 000) if the person's asthma suddenly becomes worse.

OR

☐ **Participant's Asthma First Aid Plan** (if different from above)

- In the event of an asthma attack, I agree to the participant receiving the treatment described above.
- Notify in writing if there are any changes to these instructions.

3) **KEY QUESTIONS**

a.	Has asthma interfered with participation in physical exercise within the past 12 months	NO	[ ]	YES	[ ]
b.	Has the participant required hospitalization due to asthma in the past 12 months?	NO	[ ]	YES	[ ]
c.	Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc.)?	NO	[ ]	YES	[ ]
d.	Has the participant suffered sudden severe asthma attacks requiring hospitalization within the past 12 months?	NO	[ ]	YES	[ ]
e.	Does the participant require the use of a nebulising pump as a part of your regular or emergency asthma treatment?	NO	[ ]	YES	[ ]

4) **IMPORTANT NOTE**

If any of the "KEY QUESTIONS" a, b, c, d, or e above are answered "Yes", the decision for the participant to attend rests with their doctor. A "Fitness to Participate" form must be completed by the doctor (attached). Please bring this form to the doctor with you.

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to school.

I declare that the information provided on this form is complete and correct and that I will notify the school if any changes occur. I further declare that if my child (or I for adults) is/am unable to self administer supplied medication, I give permission for trained OEG staff to administer the supplied emergency medication. I give permission for OEG to pass this information to a third party (e.g. Doctor, Hospital) to facilitate the medical treatment of my child (or myself for adults). I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on the OEG website: (oeg.org.au).

Name: _____ **Signature:** _____ **Date:** _____

Allergenic Reaction Management Form

Confidential

If necessary, seek the advice of your doctor when completing this form.

A DOUBLE DOSE OF ALL REQUIRED MEDICATION FOR THE PARTICIPANT'S ALLERGIC REACTION MUST BE BROUGHT ON THE COURSE AND NOTED ON THE MEDICAL FORM (e.g. if Epi-Pens or any other type of Auto Injector is required two must be supplied and brought on program).

Student's Name:

Name of doctor treating the student for this condition:

Doctor's Contact Phone Number:

1. What is the student allergic to?
   - Please Specify:

(e.g. Alex is allergic to penicillin and sulpher-based medications)

2. What are signs and symptoms of the person's reaction?

[ ] Low - a localised reaction (rash, itching, swelling at the site the trigger/irritant enters)

[ ] Moderate - a systemic reaction (rash, itching, swelling away from the site that trigger/irritant enters)

[ ] Severe - an anaphylactic reaction (severe breathing problem, total body swell, emergency situation)

Please give details:

3. What medication does the participant take (if any) for their allergic reaction?

4. Medication and treatment to be used during emergency situations:

"KEY QUESTIONS"

5.	Has the participant required hospitalisation due to allergies in the past 12 months?	NO	[ ]	YES	[ ]
6.	Has the participant suffered a systemic or an anaphylactic reaction (see question 2 for definition), to their allergy when triggered in the last 10 years?	NO	[ ]	YES	[ ]
7.	Does the person take, or has the person been prescribed adrenaline (Epi-pen or similar), when suffering an allergic reaction?	NO	[ ]	YES	[ ]

IMPORTANT NOTE:

If any of the "KEY QUESTIONS" 5, 6 or 7 above are answered "Yes", the decision for the participant to attend rests with their doctor. A "Fitness to Participate" form must be completed by the doctor (attached). Please bring this form to the doctor with you.

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to school.

I declare that the information provided on this form is complete and correct. I further declare that if my child (or I for adults) is/am unable to self administer supplied medication, I give permission for trained B Firm staff to administer the supplied emergency medication. I give permission for B Firm to pass this information to a third party (e.g. Doctor, Hospital) to facilitate the medical treatment of my child (or myself for adults). I give permission for B Firm to retain this form for statutory archival requirements.

Name: _____ **Signature:** _____ **Date:** _____

Fitness to Participate Form **Confidential**

School Name: _____ Year Level: _____

Name of Participant: _____ D.O.B. _____

Specific Medical Condition: (e.g. Asthma, Allergies, Epilepsy, Diabetes): _____

Notes to treating doctor

This patient is scheduled to participate in an Outdoor Education program and has self-identified a pre-existing medical condition on their medical form.

Outdoor Education & Fitness Sessions with B Firm include regular physical exercise. We operate in most weather conditions. Should you require any further information on the program, please contact us at kiz@bfirm.com.au.

B Firm staff hold either Wilderness First Aid or senior first aid.

Doctor to complete:

Based on this information above and the patient's condition, we ask that you decide on this person's suitability to participate in the upcoming program. If approved, please include specific treatment protocols to follow in the event of an emergency.

Do you approve this participant attending a B Firm session, based on their current medical condition, coupled with the demands of the program?

□ Yes □ No

What treatment protocol are you willing to authorize for this patient in the case of a medical emergency?_____
_____
_____
_____
_____

What should the B Firm staff managing this participant in the field be informed/aware of, in regards to the particular situation for this patient? What are the recommended parameters for participation in the activities?

_____
_____
_____
_____
_____

Name of Doctor: _____ **Phone:** _____

Signature of Doctor: _____ **Date:** _____

I give permission for B Firm to retain this form for statutory archival requirements.