Our Lady of Mercy College

STAFF MEDICAL REPORT FORM
OVERNIGHT CAMPS

Name of Camp: _____

This confidential medical report can be of vital importance to your safety and wellbeing. In an emergency, **it may be the only information** that other staff members or medical professionals may have for your care and treatment. Please take time to fill it in and **include all information you believe relevant**. It should be returned to the school promptly.

DETAILS

Full names: _____

Home Address: _____ Postcode: _____
(PO Box not accepted)

Phone Home: _____ Work: _____ Mobile: _____

Name of family doctor: _____ Telephone: _____

Medicare number: _____ Number on card: _____

Private Health Cover: _____ If **Yes,** Fund Name: _____ Fund No: _____

Emergency Contact:

Name: _____ Relationship to you: _____

Phone Home: _____ Work: _____ Mobile: _____

MEDICAL DETAILS

You cannot provide too much information in this section. If you have any additional information, please securely attach a separate sheet with your name on it.

Section A - Medication

Are you presently taking any medication? **YES** ☐ **NO** ☐

If **YES,** please state the condition it is treating, name of medicine, dosage and any possible side effects.

_____

_____

_____

_____

_____

_____

_____

Section B – Medical History

Do you, or have you ever suffered from the following? (Please tick the appropriate box.)

		YES	NO
i)	Asthma?	☐	☐
ii)	Allergies?	☐	☐
iii)	Diabetes?	☐	☐
iv)	Epilepsy?	☐	☐
v)	Heart/lung complaints?	☐	☐
vi)	Joint or bone injury?	☐	☐
vii)	Sleep walking?	☐	☐

If you have answered 'Yes' to any of the above, you will be required to complete the 'Medical Report form – Additional information'

Section C – Other information

Do you have any special dietary or food requirements? (e.g. vegetarian) **YES** ☐ **NO** ☐

If **Yes,** please provide details including the reasons, and what substitute food you eat:

_____

_____

_____

_____

_____

Can you swim? No ☐ Moderately ☐ Competently ☐

CONSENT – MEDICAL ATTENTION WHILE AT CAMP/EXCURSION

Where it is not practical to communicate with me, I authorise medical treatment as may be considered necessary and agree to meet any expenses, or costs incurred.

Name: _____

Signature: _____ **Date:** _____

* Please advise the school in writing **PRIOR** to this excursion/camp, of any changes to this information or **CURRENT** illness or condition.

Any additional information

_____

_____

_____

_____

_____

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STAFF MEDICAL REPORT FORM ADDITIONAL INFORMATION

(Only required if you ticked 'Yes' to any of the questions in Section B – Medical History)

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Please complete if you have a Medical Condition:
Condition 1: (Provide further information for EACH condition on separate pages).

a. Provide a full description of your condition.

b. If you require medication, please list the dosage, frequency and storage regarding this medication.

c. List and describe any 'triggers' that will bring on or exacerbate the condition.

d. Fully describe the signs or symptoms of the condition. (rash, fever, swelling etc.)

e. Provide a detailed treatment plan, including steps to be taken if the condition worsens and the level of assistance required increases. (eg. Wheelchair, oxygen, physical support etc.)

f. Have you ever been hospitalised due to the condition? If yes, please supply date.

g. Provide any other relevant information not listed above.