West Beechboro Primary School

Independent Public School

STUDENT HEALTH FORM

Year: **Room:**

Student's name: Date of birth:

Parent/Caregiver's full name:

Address: Postcode:

Telephone no. – home:

– work:

– mobile:

Name of family doctor: Telephone no:

Medical Practice (Name & Address):

Medical details

Is your child subject to seizures, fainting, epilepsy, diabetes or any other condition?

Yes ☐ No ☐

If "yes", please give details:

Is your child allergic to:

Penicillin	☐	*(Please give details)*
Any other drug	☐	
Any food	☐	
Other	☐	

Date of last tetanus vaccination:

Medication

Parents/Caregivers are requested to make arrangements with the Deputy Principal for the safekeeping and handling of prescribed medications.

Is your child presently taking tablets and/or other forms of prescribed medication? Yes ☐ No ☐

Does your child self-administer the medication? Yes ☐ No ☐

If "yes", state name of medication, dosage and frequency of use:

Does your child have a current Health Care Authorisation Plan at school? Yes ☐ No ☐

Other information

Please provide any other information regarding your child's health that you may consider beneficial to his/her wellbeing.

Parent/Caregiver's Signature……..……Date……..

Avignon Way · Beechboro · WA · 6063 Tel: 08 9377 6091 · Fax: 08 9377 6815

Founding member of the 'Coalition of Schools.'