18. Health Profile

**Student Information**

**Name: Year:**

**Address:**

**Student email: Student cellphone:**

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| --- | --- | --- |
| **1 1 Please tick if your child has any of the following:**  🞎 Migraine  🞎 Epilepsy  🞎 Asthma  🞎 Diabetes  🞎 Travel Sickness  🞎 Fits of any type  🞎 Chronic nose bleeds  🞎 Heart Condition  🞎 Dizzy Spells  🞎 Colour Blindness  🞎 Other – Please specify  ………………………………….………..…….…………………………  **2 Medical Alert Number**  (if applicable)  …………………………………….…….…….…………………………  **3 Date of last tetanus injection?**  …….../….…../….…..  **4 Is your child currently taking medication?**  🞎 No  🞎 Yes – Please state ailment/s …………………………………………..…………………….……………  Name of medication/s  ………………………………………......………………….………………  Dosage & time/s to be taken  …………………………………………...…………………….……………  Other treatment  ………………………………………  ……………………….…………… | **5 Has your child had any major injuries (breaks or strains) or illness (glandular fever etc.) in the last six months that may limit full participation in any activities?**  🞎 No  🞎 Yes – Please specify  ………………………………………………  ………………………………………………  **6 Is your child allergic to any of the following?**  Prescription medication  🞎 No  🞎 Yes – Please specify  ………………………………………………  ………………………………………………  Food  🞎 No  🞎 Yes – Please specify  ………………………………………………  ………………………………………………  Insect bites/stings  🞎 No  🞎 Yes – Please specify  ………………………………………………  ………………………………………………  Other allergies  🞎 No  🞎 Yes – Please specify  ………………………………………………  ………………………………………………  Treatment required?  ………………………………………………  ……………………………………………… | **7 Outline any dietary requirements?**  ……………………………………………….….……………………………………  **8 What pain/flu medication may your child be given if necessary?**  ……………………………………………….….……………………………………  **9 To the best of your knowledge, has your child been in contact with any contagious or infectious diseases in the last four weeks?**  🞎 No  🞎 Yes – please give brief details  ……………………………………………….….….…………………………………  **10 Is there any other information that staff should know to ensure the physical and emotional safety of your child? Eg. Cultural practices, disability, anxiety about heights/darkness/small places, pregnancy, behavioural or emotional problems)**  🞎 No  🞎 Yes – please give brief details  ……………………………………………….….…………………………………… |

**Please take time to update health information with the school office if there are any changes during the year.**