



Student Information Form (confidential)

PLEASE COMPLETE & BRING THIS FORM TO YOUR ENROLMENT INTERVIEW

The *School Education Act 1999* requires the provision for, "Details of any condition of the enrollee that may call for special steps to be taken for the benefit or protection of the enrollee or other persons in the school" (s.16G).

To assist the school in responding to individual requirements, please detail any special needs your child has that may impact his/her learning, participation or welfare during school hours or at school-related activities (carnivals, camps, excursions, etc). Non-disclosure of any medical or learning support conditions may affect the status of the enrolment at a later stage.

STUDENT DETAILS – MEDICAL SUMMARY

Surname: _____ First Name: _____
(name must be as appears on birth certificate)

Middle Name: _____

Doctors Name: _____ Medical Centre: _____

Phone Number: _____ Medicare Number: _____

Medicare Card Position: _____ Medicare Expiry: _____

Private Health Fund Provider: _____ Health Member No: _____

Ambulance Cover: Yes No

If applicable, please indicate your child's disability/medical condition in any of the following areas.

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Eyesight |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Wears glasses/contacts |
| <input type="checkbox"/> Physical Disability/Mobility | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Asthma <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Allergy/Anaphylaxis <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe | |
| <input type="checkbox"/> Requires Epipen | |

Please provide additional details:

Has your child's Medical Practitioner provided a health care plan to assist the school to manage the above condition? Yes (if yes, please provide current health care plan) No

External Service Provider:

Does your child receive any services from an external agency, which may affect education arrangements?

Yes If yes, please detail type or service, name of service provider and Contact Number No
