



## MEDICAL INFORMATION 2012

### EMERGENCY CONTACT 1

NAME: \_\_\_\_\_ PHONE HOME: \_\_\_\_\_

MOBILE: \_\_\_\_\_ WORK: \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

### EMERGENCY CONTACT 2

NAME: \_\_\_\_\_ PHONE HOME: \_\_\_\_\_

MOBILE: \_\_\_\_\_ WORK: \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

DOCTOR: NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DENTIST: NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

### RELEVANT MEDICAL HISTORY

Is there any pre - existing condition, disability, impairment, illness or Injury

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### LIST ANY PERMANENT MEDICATIONS & OR TREATMENT WITH POSSIBLE SIDE EFFECTS BELOW:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE ATTACH ASTHMA MANAGEMENT PLAN IF APPLICABLE

MEDICARE NO: \_\_\_\_\_ AMBULANCE YES / NO NUMBER \_\_\_\_\_

PRIVATE HEALTH FUND & NUMBER \_\_\_\_\_

### AUTHORISATION

1. If my child/ myself (Senior Pupil) is involved in an emergency situation, I accept **JOULLE CALISTHENIC ACADEMY INC & THEIR REPRESENTATIVES** to act in the best interests of my child & to notify me as soon as possible.
2. I give permission for contact to be made with the relevant authority
3. I will be responsible for any costs arising from such action.
4. **If there are any changes in my child's medication I understand it is my responsibility to notify JOULLE CALISTHENIC ACADEMY INC**

SIGNATURE: \_\_\_\_\_ DATE    /    /   

PRINT NAME: \_\_\_\_\_ RELATIONSHIP TO PUPIL: \_\_\_\_\_