MOUNT CARMEL COLLEGE

A Catholic Co-educational Years 8 – 12 Secondary School in the Josephite Tradition.

Campus: 33 Newcastle Street, Rosewater SOUTH AUSTRALIA 5013
Postal Address: PO Box 35, Port Adelaide Business Centre SOUTH AUSTRALIA 5015
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Web: www.mcc.catholic.edu.au
CRICOS Provider Code: 02237G

2014 STUDENT RECORD – MEDICAL & HEALTH

The safety, wellbeing and health of your child is vitally important to us. We aim to assist students and Parents/Guardians in all matters, but can only do so with your full cooperation. Please complete the following information and return it to the College. It is important that this information is updated annually or whenever there is a change in conditions/information. If you fail or neglect to provide sufficient and/or current information in writing to enable the proper treatment of your child, no liability will be accepted by the College for any injury or illness which your child may suffer as a result.

STUDENT'S LAST NAME	**HOME GROUP**
STUDENT'S FIRST NAME/S	**DATE OF BIRTH**
Address	
Suburb	Postcode
Home Phone No.	Medicare No.
Name of Student's Doctor	Phone No.
Address	
Name of Student's Dentist/Dental Clinic	Phone No.
Address	

With whom does the student live ☐ Mother/Father/Guardian ☐ Mother/Guardian ☐ Father/Guardian ☐ Other

If other, please provide details

EMERGENCY CONTACTS

In case of an emergency at school we shall try to contact Parents/Guardians first.

MOTHER'S/GUARDIAN'S LAST NAME		FIRST NAME/S
Home Phone No.	Business Phone No.	Mobile No.

Any information that would help us to contact you in a case of an emergency

FATHER'S/GUARDIAN'S LAST NAME		FIRST NAME/S	
Home Phone No.	Work Phone No.	Mobile No.	Email

Any other information that would help us to contact you in a case of an emergency:

In the event that Parents/Guardians are unable to be contacted, please provide details of two other emergency contacts.

1. ☐ Mr ☐ Mrs ☐ Miss ☐ Ms FULL NAME

Address		
Home Phone No.	Business Phone No.	Mobile No.
Relationship to student		

2. ☐ Mr ☐ Mrs ☐ Miss ☐ Ms FULL NAME

Address		
Home Phone No.	Business Phone No.	Mobile No.
Relationship to student		

MEDICAL CONDITION/S

Does your child have any medical condition(s) or health problem(s) that might affect them?

In the classroom	☐ Yes ☐ No	During physical education or sport	☐ Yes ☐ No	During camps; aquatics; other activities	☐ Yes ☐ No

What is the nature of the condition?

How could it affect your child?

What treatment is required?

CRITICAL CONDITION/S

Does your child suffer from a critical condition(s) which could require treatment at school?

Allergies/Bee stings/Peanuts	☐ Yes ☐ No	Asthma/other chest problems	☐ Yes ☐ No
Convulsions/seizures	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Vision or hearing impairments	☐ Yes ☐ No	Other *(please specify)*	

If you have ticked any of the above, please have your doctor complete a ***Medication Plan*** and return it to the College *(copies of this Plan are available from the College Front Office).*

SPECIAL AIDS

Does your child need to use any special aids at school? eg. glasses, hearing aids, wheelchairs etc. ☐ Yes ☐ No

If yes, please provide details

PARENTAL/GUARDIAN AUTHORITY AND CONSENT

To: Mount Carmel College

I ______________________________

(Parent – Mother/Father/Legal Guardian (circle as appropriate)

of ______________________________ hereby:

Student's Name ("my child")

1. Consent to the College seeking such medical or dental service advice on behalf of my child as it sees fit in the event of accident or illness. If in the opinion of an attending medical or dental practitioner my child requires medical or dental attention or treatment, I consent to this being carried out. (However, I understand every effort will be made to contact Parents/Guardians for permission if at all possible).
2. Certify that the consent which I have given in paragraph (1) is valid at all times while my child is in the custody of the College, including but not limited to such times as my child is at school, is present at school camps or is attending or participating in a work experience program, excursion, function or school activity.
3. *(If applicable).* Give notice that my child suffers from the following illnesses or disabilities and/or takes medication which might interfere with or inhibit any medical or dental attention or treatment.

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4. Consent to the College providing sunscreen to my child on appropriate occasions.
5. Understand that the College may call for an ambulance, and its membership covers the cost of transport to hospital.
6. Certify that I understand that the College will take all reasonable care in the event of my child suffering accident or illness, but that it will not be responsible for the costs of any medical or dental attention or treatment administered to my child in such event nor will it be responsible directly or indirectly for any act or omission of any medical or dental practitioner or medical officer attending or treating my child.
7. Accept that the Staff may take whatever action they deem necessary to ensure the health, safety and welfare of my child in accordance with the College's policies.

Parent/Guardian Signature: ______________________ Date: ______________________

IF THERE IS ANY CHANGE OF ADDRESS, CONTACT DETAILS, MEDICAL CONDITIONS ETC, PLEASE INFORM THE COLLEGE ASAP SO THAT RECORDS ARE CURRENT AND CAN BE UPDATED. SHOULD YOU WISH TO DISCUSS THE HEALTH OF YOUR CHILD, PLEASE ARRANGE AN APPOINTMENT WITH THE PRINCIPAL /DEPUTY PRINCIPAL.