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CHURCHLANDS SENIOR HIGH SCHOOL
An Independent Public School

STUDENT HEALTH FORM

STRICTLY CONFIDENTIAL

This information is required for each student participating in Workplace Learning. It will assist the school and Workplace Learning coordinator in the preparation and planning of the work placement.

Student Details

Student Full Name: Date of Birth:

Medicare Number:

Parent/Guardian Name: Mobile:

Parent/ Guardian Email address:

Emergency Contact Details (If different to the above):

Medical Information

Doctors Name/ Medical practice: Doctors Telephone:

Doctors Address:

Medical Details - (Please attach any Emergency response plans if applicable)

Does your child have any existing medical or mental health conditions? (If none please write N/A)

Is your child subject to seizures, fainting, epilepsy, diabetes, or any other condition that may affect safety during the workplace learning placement? **Yes** ☐ **No** ☐

If "Yes," please provide details:

Allergies
Is your child allergic to any of the following? (Please tick) **Penicillin** ☐ **Other Drugs** ☐ **Food** ☐ **Other** ☐ **N/A** ☐
If "Yes," please provide details:

Parents/guardians are requested to make arrangements with the workplace learning coordinator for safekeeping and handling of prescribed medications, prior to the workplace learning placement.

Is your child currently taking prescribed medication? **Yes** ☐ **No** ☐

Does your child self-administer the medication? **Yes** ☐ **No** ☐
If "yes", state name of medication, dosage and frequency of use:

Parental Consent

I give permission for the disclosure of any health-related issues that may impact the workplace learning placement organised for my child

Parent/Guardian Signature: **Date:**