DE LA SALLE COLLEGE
HEALTH CONSENT FORM 20___

Student Name		Date of Birth: Year Level:	

Health Information

Current Doctor: Medical Centre:

Medical Conditions/Allergies (Please circle and provide details)

Heart Condition	YES NO	Allergies, If Yes please give details	YES NO
Rheumatic Fever	YES NO	Other	
Diabetes	YES NO	Is he on any regular medication and or has a medical condition that the school should be aware of? If Yes, please give details.	YES NO
Asthma	YES NO		
Does your son wear glasses or hearing aids?	YES NO		

Health Consent

	PLEASE CIRCLE
Has your son been fully immunised? Please attach a copy of his immunization record.	YES NO
I give permission for the school nurse to provide healthcare and a full Year 9 health check - this will include measuring height, weight, hearing, vision and blood pressure, plus a discussion on health factors relating to home, school friends and adolescent health issues. (Parents will be notified if necessary and you are welcome to contact the nurse with any questions).	YES NO
I give permission for my son to have access to the range of services provided by the staff of the Student Health Centre ie Nurse, Guidance Counsellor, Social worker	YES NO
I give permission for the School Nurse to give my son general medication eg Panadol, ibuprofen and eno if necessary.	YES NO
I give permission for my son to be taken to an Emergency Medical Service in the event of an accident or emergency when the school cannot contact me. I agree to meet the cost incurred for this.	YES NO
I give permission for my son to register with the Mobile Mighty Mouth Dental Clinic that comes our school.	YES NO

Name & Signature		Date	
Your Relationship to Student			