



Transfer Students Medical Details

239 Pearcedale Road Cranbourne South VIC 3977 Tel: 9782 2999

Email: cranbourne.south.ps@edumail.vic.gov.au Website: <http://www.cranbournesouth.vic.edu.au/>

Students Name	Date of Birth
Does the student have any ongoing medical conditions? (tick) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please complete the boxes below. If No, please turn over to complete this form.	
<input type="checkbox"/> Migraine	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Eczema
In the comment section below, please write any instructions for staff, regarding the conditions listed above.	
Comments	
<i>If medication is necessary during school hours, you will need to arrange a meeting with the school First Aid Officer.</i>	

The following conditions require an action plan signed by a doctor and an interview with the school First Aid Officer. <i>Links are below.</i>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies (including Anaphylaxis)
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes
Other	
<i>If medication is necessary during school hours, you will need to arrange a meeting with the school First Aid Officer</i>	

LINKS FOR ACTION PLANS

TO BE COMPLETED BY A MEDICAL PRACTITIONER.

Asthma Plans: <https://www.asthmaaustralia.org.au/vic/about-asthma/resources/victorian-action-plans/victorian-asthma-action-plans>

Allergy Action Plan: <https://www.allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis>

Epilepsy Medical Management Plan: <http://epilepsyfoundation.org.au/epilepsy-management-plans/>

Diabetes Action and Management Plans: <https://www.diabetesvic.org.au/Diabetes-in-Victorian-schools-and-early-childhood-settings?bdc=1>



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EMERGENCY CONTACTS

Other than parents or guardians

	<i>Name</i>	<i>Relationship</i>	<i>Telephone Contact</i>	
1				
2				
3				

DOCTOR DETAILS

Doctor's Name:	
Individual or Group Practice: (tick)	<input type="checkbox"/> Individual <input type="checkbox"/> Group
No. & Street or PO Box No.:	
Suburb:	
State:	Postcode:
Telephone Number	
Student Medicare Number:	

I certify that the information contained within this form is correct.

Signature of Parent/Guardian: _____ Date: ____ / ____ / ____

Please note: Whenever possible, antibiotics and any other temporary medications should be scheduled outside the school hours e.g. medications required three times a day are not required to be taken during school hours.