

ST JOSEPH'S CATHOLIC PRIMARY SCHOOL  
51 Altair Street, Southern Cross WA 6426

MEDICAL INFORMATION FORM

GIVEN NAME \_\_\_\_\_ SURNAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NO: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ RELIGION \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

(IF DIFFERENT FROM ABOVE)

TELEPHONE (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

ARE YOU IN: MEDICAL INSURANCE FUND? (YES/NO) Please circle ST JOHN'S AMBULANCE? (YES/NO)

NAME OF FUND \_\_\_\_\_ MEMBERSHIP NUMBER \_\_\_\_\_

MEMBERSHIP NUMBER \_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_

IS YOUR CHILD'S TETANUS BOOSTER UP TO DATE? YES/NO Please circle

PLEASE INDICATE IF YOUR CHILD HAS ANY OF THE FOLLOWING HEALTH CONDITIONS AND THEN PLEASE SPECIFY ANY DETAILS THAT MAY BE RELEVANT

(a) **Heart Problems** YES/NO specify \_\_\_\_\_

(b) **Respiratory Problems**  
(1) Asthma YES/NO \_\_\_\_\_  
(2) Other YES/NO \_\_\_\_\_

(c) **Allergies**  
(1) Food YES/NO \_\_\_\_\_  
(2) Drugs YES/NO \_\_\_\_\_  
(3) Ointments YES/NO \_\_\_\_\_  
(4) Other YES/NO \_\_\_\_\_

(d) **Diabetes** YES/NO \_\_\_\_\_

(e) **Blood pressure** YES/NO \_\_\_\_\_

(f) **Recent Operations** YES/NO \_\_\_\_\_

(g) **Epilepsy** YES/NO \_\_\_\_\_

(h) **Recent Illnesses** YES/NO \_\_\_\_\_

(i) **Phobias** YES/NO \_\_\_\_\_

(j) **Bed-Wetting** YES/NO \_\_\_\_\_

(k) **Vegetarian** YES/NO \_\_\_\_\_

(l) **Other** Specify \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_