



Wider Living Week

Monday, 3 December to Thursday, 6 December 2019

HEALTH PROFILE

Name _____ Class: _____

Medic alert number (if applicable): _____

1. Does your child suffer from any of the following? YES / NO

If YES, please circle:

Migraine Epilepsy Asthma Diabetes Travel sickness Fits of any type

Nose bleeds Heart condition Dizzy spells Claustrophobia

Allergies (circle those that apply) Stings Bites Food Medication (including penicillin).

Other (please detail):

Please write any prevention and treatment details we might need to know:

2. Is your child currently taking any medication? YES / NO

If yes, name of medication: _____

Ailment: _____

Will the student monitor his/her own medication or is supervision required? _____

If supervision required, please write details - dosage, times etc:

3. Has your child had any significant injuries or suffered from sickness that may limit full participation? YES / NO

If yes – please detail:

4. When was your child's last tetanus injection? (if known)_____

5. What pain/ flu/ allergy medication may your child be given if deemed necessary?

None / Any / or specify:

6. To the best of your knowledge, has your child been in contact with any contagious or infectious diseases in the last 4 weeks? YES / NO

If YES, please give details:

7. Is there any information that the staff should know to ensure the physical and emotional safety of your child? YES / NO

For example, cultural practises, disability, fear of heights/space spaces, anxiety, pregnancy, behavioural or emotional problems.

If YES, please give details:

8. Does your child have any specific dietary requirements? YES / NO

If YES, please give details:

9. Some WLW activities may involve swimming in pools or the ocean.

Is your child a competent swimmer

YES / NO

Are they more or less confident in the following areas? Pool, Open sea water. Deep water?

Please give details

EMERGENCY CONTACT DETAILS:

Please provide two sets of contact details:

Name of emergency contact:

Name of backup emergency contact:

Relationship to student:

Relationship to student:

Day time landline number:

Day time landline number:

Night time landline number:

Night time landline number:

Mobile number:

Mobile number:

I will inform the school as soon as possible of any changes in the medical or other circumstances between now and this field trip.

I agree to my child receiving any emergency medical, dental, or surgical treatment including anaesthetic or blood transfusion, as considered necessary by the medical authorities present. Any medical costs not covered by ACC will be paid by me.

If prescribed medication needs to be given, a designated adult will be assigned to do this. I will ensure that the medication is clearly labelled, securely fastened and handed to the designated adult with instructions on administration.

Print name: _____

Relationship to student: _____

Signed: _____

Date: _____