

Medical Details and Health Conditions

Name _____ D.O.B. _____

Emergency Contact

Name _____ Phone /Mobile Number _____

ALLERGIES – THESE CAN INCLUDE ALLAERGIES TO INSECT STINGS, DRUGS, LATEX ,FOOD (EG NUTS,EGGS,PEANUTS)OR OTHER.

If your child has an allergy, please specify in the box below. For this allergy answer the questions that follow (where applicable). If there is insufficient space, please write on the back or attach an additional sheet.

ALLERGY TO _____

- | | | |
|---|-----|----|
| • Has a doctor diagnosed this allergy? | YES | NO |
| • Is this a severe allergy (anaphylaxis)? | YES | NO |
| Anaphylaxis is a severe, potentially life-threatening, allergic reaction. | | |
| • Has your child been hospitalised with a severe allergic reaction, anaphylaxis or any other allergy? | YES | NO |
| • Does your child have an action plan for anaphylaxis? | YES | NO |
| • If yes is this plan attached? | YES | NO |
| • Has your child been prescribed an adrenaline autoinjector (i.e. EpiPen)? | YES | NO |
| • Does your child have an action plan for Allergic Reactions? | YES | NO |
| • If yes is this plan attached? | YES | NO |
| • Please list any other medications prescribed for this allergy | YES | NO |

MEDICAL CONDITIONS OTHER THAN ALLERGIES AND ANAPHYLAXIS (e.g. ASTHMA, SEVERE ASTHMA DIABETES, EPILEPSY OR PHYSICAL CONDITIONS)

Please identify and provide details below of any other medical condition for which your child is being treated. If more than one or insufficient space please write on the back or on an additional sheet of paper.

MEDICAL CONDITION _____

- | | | |
|--|-----|----|
| • Has a doctor or physiotherapist diagnosed this condition? | YES | NO |
| • Has your child been hospitalised with this condition? | YES | NO |
| • Does your child have a documented action plan (e.g Asthma action plan) from a doctor/Physio? | YES | NO |
| • If yes, is this plan attached? | YES | NO |
| • Is your child taking prescribed medication or treatment for this condition or injury? | YES | NO |
| • If yes, what is the prescribed medication or treatment? | YES | NO |

PARENT/CARER'S SIGNATURE _____ DATE _____