ST PAUL'S CATHOLIC PRIMARY SCHOOL

# STUDENT INFORMATION FORM

## STUDENT DETAILS

| | | |
|---|---|---|
| Surname: | | |
| Given name/s: | | |
| Address: | | |
| Suburb: | State: | Postcode: |
| Date of birth: | | |

## STUDENT INDIVIDUAL NEEDS

The School Education Act 1999 requires the provision of:
"Details of any condition of the enrolee that may call for special steps to be taken for the benefit or protection of the enrolee or other persons in the school" (16G).
To assist the school to respond to individual requirements, please detail any special needs your child has in the following area(s) that may affect his/her learning, participation or welfare during school hours.

| | | | | |
|---|---|---|---|---|
| Medical/Health Care: | | | | |
| Medication: | | | | |
| Physical: | | | | |
| Orthoses/Prostheses | | | | |
| Psychological/Cognitive: | | | | |
| Sensory (eg. vision/hearing): | | | | |
| Behavioural or Safety: | | | | |
| Communication: | | | | |
| Allergies: | | | | |
| Has your child been prescribed an EpiPen? | ☐ Yes | ☐ No | | |
| Does your child receive any services from an external agency that may affect educational arrangements? | ☐ Yes | ☐ No | | |
| If yes, please complete the following details: | | | | |
| Name of service provider and contact number: | | | | |
| Reason for use of external agency: | | | | |
| Does your child require special transport arrangements to and from school? | ☐ Yes | ☐ No | | |
| Does your child receive respite care on a regular basis? | ☐ Yes | ☐ No | | |

## MEDICAL INFORMATION

| | | | |
|---|---|---|---|
| Family Doctor / Medical Clinic: | | Contact Number: | |
| Address: | | | |
| Dentist / Dental Clinic: | | Contact Number: | |
| Address: | | | |
| Medicare Number: | | Card Position: | |
| Private Health Fund: | | Policy Number: | |
| Blood Group (if known): | | | |

## IMMUNISATION

Immunisation:

***A copy of the Immunisation Record must be provided. Record should be no older than 6 months from date of enrolment application.***

## MEDICAL EMERGENCY AUTHORISATION

I authorise St Paul's Catholic Primary School to seek medical/dental attention, call an ambulance or to hospitalise my son/daughter when considered necessary. I further authorise the school that if an emergency occurs requiring surgery, anaesthetic, oxygen, blood transfusion, medication and I am unable to be contacted within a reasonable time, the school has the authority to agree to medically recommended treatment by an accredited medical practitioner on my behalf.

| | |
|---|---|
| Signature of Parent/Guardian: | Date: |
| Signature of Parent/Guardian: | Date: |