



Bounty Boulevard State School Student Medical Details

Student's Name: _____ Year Level: _____ Roll Class: _____

Doctor's Information:

Doctor's Name:	Telephone no:
Practice Address:	

Medical conditions: (Please select as appropriate)

- My child **does not have** any known medical conditions
- My child **has** the following known medical conditions (Please provide Medical Action Plans from your doctor where required.)

Please refer to the Education Queensland Standardised Medical Condition Category List on reverse when completing this section.

Medical Condition 1:	
Medical Condition Category: <i>(Please use list of Medical Condition Categories provided)</i>	
Symptoms: <i>(Include specific medical condition name if known and any symptoms school should look for)</i>	
Management: <i>(Include any special instructions the school should follow with regard to this condition)</i>	

Medical Condition 2:	
Medical Condition Category: <i>(Please use list of Medical Condition Categories provided)</i>	
Symptoms: <i>(Include specific medical condition name if known and any symptoms school should look for)</i>	
Management: <i>(Include any special instructions the school should follow with regard to this condition)</i>	

Medical Condition 3:	
Medical Condition Category: <i>(Please use list of Medical Condition Categories provided)</i>	
Symptoms: <i>(Include specific medical condition name if known and any symptoms school should look for)</i>	
Management: <i>(Include any special instructions the school should follow with regard to this condition)</i>	

If your child has additional medical conditions please attach details of all medical conditions.

Education Queensland Standardised Medical Condition Category List

Acquired brain injury	Diabetes - type one
Allergies /Sensitivities	Diabetes - type two
Anaphylaxis	Ear/hearing disorders - Otitis Media (middle ear infection)
Airway/lung/breathing - Oxygen required (continuously/periodically)	Ear/hearing disorders - Hearing loss
Airway/lung/breathing - Suctioning	Ear/hearing disorders - Other
Airway/lung/breathing -Tracheostomy	Epilepsy - Seizure
Airway/lung/breathing -Other	Eye/vision disorders
Artificial feeding - Gastrostomy device (tube or button)	Endocrine disorder - Adrenal hypoplasia, pituitary, thyroid
Artificial feeding - Nasogastric tube	Heart/cardiac conditions - Heart valve disorders
Artificial feeding - Jejunostomy tube	Heart/cardiac conditions - Heart genetic malformations
Artificial feeding - Other	Heart/cardiac conditions - other
Asthma	Mental Health - Depression
Attention-deficit /Hyperactivity disorder (ADHD)	Mental Health - Anxiety
Bladder and bowel - Urinary wetting, incontinence	Mental Health - Oppositional defiant disorder
Bladder and bowel - Faecal soiling, constipation, incontinence	Mental Health - Other
Bladder and bowel - Catheterisation (continuous, clean intermittent)	Muscle/bone / musculoskeletal disorders - spasticity (Baclofen Pump)
Bladder and bowel - Stoma site, urostomy, Mitrofanoff, MACE, Chair	Muscle/bone / musculoskeletal disorders - Other
Bladder and bowel - Other	Skin Disorders - eczema
Blood disorders - Haemophilia	Skin Disorders - psoriasis
Blood disorders - Thalassaemia	Swallowing/dysphagia - requiring modified foods
Blood disorders - Other	Swallowing/dysphagia - requiring artificial feeding
Cancer / oncology	Transfer & positioning difficulties
Coeliac disease	Travel / motion sickness
Cystic Fibrosis	Other

Medication:

Does your child have any regular prescribed medication (long term only)? Yes No
 (If yes and the medication needs to be administered during school hours, a separate medication form will need to be completed. This form is available from the Administration Office)

Name of medication:	1.
	2.
	3.
	4.

Physical:

Does your child have any area of concern in physical development the school should know about? Yes No
 (If yes, please provide details below. Attach a separate sheet if necessary with your child name clearly marked)

Eyes:	Ears:
Speech:	Physical Difficulties:
Motor-Coordination/Balance:	
Other:	
Restrictions on Student Activities (e.g. swimming, sport, camps, etc)	

Immunisation: (Please provide a copy of your child's immunisation records with this document)

Is your child's immunisation up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Tetanus Needle:	Year:	
Name of last immunisation:		Date:	

Parent / Carer's Name

Parent / Carer's Signature

Date