

ENROLMENT MEDICAL REGISTER POLICY

POLICY STATEMENT

Pursuant to DET and Upwey Primary School enrolment policies, a record or database of students' medical condition/s is collected through the [Student Enrolment Form](#) (pp 9-10) – an excerpt of the applicable sections of this form is provided in Appendix 1.

Any amendments to a student's record can be made by the parent/guardian completing the applicable sections of the Student Enrolment Form. This may include but not limited to:

- A new medical condition when there is no other similar condition existing within the database.
- Modify a medical condition description for further clarification or description.

Deleting a medical condition should only occur when there is a similar duplicate medical condition existing in the database or student record.

EVALUATION

This policy will be reviewed annually or more often if necessary due to changes in regulations or circumstances.

APPENDIX 1

Student Enrolment Form excerpt (pp. 9-10)

STUDENT MEDICAL DETAILS

MEDICAL CONDITION DETAILS:

Does the student suffer from any of the following impairments? (tick)	Hearing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No	Mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the student suffer from Asthma? (tick) If No, please go to the Other Medical Conditions section		<input type="checkbox"/> Yes <input type="checkbox"/> No

ASTHMA MEDICAL CONDITION DETAILS:

Answer the following questions **ONLY** if the student suffers from any asthma medical conditions.

Please indicate if the student suffers from any of the following symptoms: (tick)		If my child displays any of these symptoms please: (tick)	
<input type="checkbox"/> Cough		Inform Doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Difficulty Breathing		Inform Emergency Contact	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Wheeze		Administer Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Exhibits symptoms after exertion		Other Medical Action	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tight Chest		If yes, please specify:	
Has an Asthma Management Plan been provided to School?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the student take medication? (tick)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of medication taken:	
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)		<input type="checkbox"/> Preventative <input type="checkbox"/> Response	
Indicate the usual dosage of medication taken:		Indicate how frequently the medication is taken:	
Medication is usually administered by: (tick)		<input type="checkbox"/> Student <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Other	
Medication is stored: (tick)		<input type="checkbox"/> with Student <input type="checkbox"/> with Nurse <input type="checkbox"/> Fridge in Staff Room <input type="checkbox"/> Elsewhere	
Dosage time	Reminder required? (tick)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poison Rating

OTHER MEDICAL CONDITIONS

(More copies of the other medical condition forms are available on request from the school.)

Does the student have any other medical condition? (tick)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify:			
Symptoms:			
If my child displays any of the symptoms above please: (tick)			
Inform Doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inform Emergency Contact	<input type="checkbox"/> Yes <input type="checkbox"/> No
Administer Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Action	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify:			
Does the student take medication? (tick)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of medication taken:	
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)		<input type="checkbox"/> Preventative <input type="checkbox"/> Response	
Indicate the usual dosage of medication taken:		Indicate how frequently the medication is taken:	
Medication is usually administered by: (tick)		<input type="checkbox"/> Student <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Other	
Medication is stored: (tick)		<input type="checkbox"/> with Student <input type="checkbox"/> with Nurse <input type="checkbox"/> Fridge in Staff Room <input type="checkbox"/> Elsewhere	
Dosage time	Reminder required? (tick)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poison Rating

STUDENT DOCTOR DETAILS

The following details should **only** be provided if **this** student has a Doctor and/or Medicare number different to the Primary Family.

Doctor's Name:			
Individual or Group Practice: (tick)			<input type="checkbox"/> Individual <input type="checkbox"/> Group
No. & Street or PO Box No.:			
Suburb:			
State:		Postcode:	
Telephone Number		Fax Number	
Student Medicare Number:			

STUDENT EMERGENCY CONTACTS

This section should **ONLY** be filled out if **THIS** student has emergency contacts other than the Prime Family Emergency Contacts.

	<i>Name</i>	<i>Relationship</i> (Neighbour, Relative, Friend or Other)	<i>Language Spoken</i> (If English Write "E")	<i>Telephone Contact</i>
1				
2				

APPROVED BY SCHOOL COUNCIL....

