Health Enrolment Form

If you answer yes to any of the shaded areas on this form, please complete a Student referral – request for nursing services form and forward to your regional State Schools Nursing Service.

Does your child have or require any of the following:

Student Details

Name: _____ **School:** _____ **Date of Birth:** ___/___/___

Parent/Guardian/Carer Details

Name: _____

Address: _____

Email Address: _____

Contact Numbers: (Home) (Work) (Mobile)

Student Medical Details

Medical Diagnosis/Conditions:

Emergency contact name and number:

Medical Condition/Requirement	Yes	No	Comment and Provide Details (if answered 'Yes')
Anaphylaxis			Complete a "Request to Administer Medication" and provide an Anaphylaxis Plan completed by specialist or GP
Asthma			Complete a "Request to Administer Medication" and provide an Asthma Plan completed by specialist or GP
Administration of Oxygen			Medical prescription required and cylinders provided from home
Colostomy/Illeostomy			
Diabetes/BGL Monitoring			
Emergency Medication			Complete a "Request to Administer Medication"
Epilepsy and/or Seizures (including Absences)			
Gastrostomy Tube/Button			
Naso-Gastric Tube			
Suctioning of Airways			
Tracheostomy			
Shunt			
Urinary Catheterisation or Continence Issues/Problems			
Allergies or Sensitivities (medication or other)			

Privacy Notice

The Department of Education, Training and Employment (DETE) will only record, use and disclose the personal information of a student in accordance with Section 426 of the Education (General Provisions) Act 2006. The information will only be accessed by authorised departmental employees and will not be disclosed other than in accordance with this Act

Form last updated: 17/4/13

Interpreter

Queensland Government

Other, E.g. surgery			

Emergency Health Plans

Does your child currently have an Emergency Health Plan?

☐ **No** ☐ **Yes (Provide details, and forward a copy of any current Procedure and Plans to the school)**

Please Specify Type of Procedure: _____

_____

_____

Specialised Health Procedures

Does your child require assistance with any Specialised Health Procedures while at school?

☐ **No** ☐ **Yes (Provide details, and forward a copy of any current Procedure and Plans to the school)**

Please Specify Type of Procedure: _____

_____

_____

Health Service Providers Contact Details

Name of Health Provider		Contact Details
Family Doctor (GP):		
Paediatrician:		
Hospital of choice:		
Neurologist/Neurosurgeon:		
Gastroenterologist:		
Others:		

Parent/Carer/Guardian Name: _____

Signature: _____ **Date:** _____

State Schools Registered Nurse Use Only

Actions/Comments: ……

……

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Name: …….. **Signature:** …….. **Date:** ……. / ……. / …….

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