ST HILDA'S SCHOOL
GOLD COAST

Contact and Medical Form OSHC

This form is to be completed fully and accurately for the safety of your child during the Vacation care.
Student's Full Name _____ Date of Birth: _____

Address: _____

_____

Parent's Full Name: _____ Date of Birth: _____

Mobile: _____Phone No.: _____

Emergency Contact Person: _____

Mobile: _____Phone No: _____

Medical Details:

My Child has a disability that may affect him/her (please tick): ☐ Yes ☐ No

Please tick: If yes, please give details below

Heart Problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Recent Operations	☐ Yes	☐ No
Allergies:	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Other:	☐ Yes	☐ No	Recent Illness	☐ Yes	☐ No
Details:			Phobias	☐ Yes	☐ No
			ADD/ADHD	☐ Yes	☐ No

Dietary Requirements: Details: _____

_____ _____

Additional details: _____

_____

Has your child been immunized ☐ Yes ☐ No If not, please give details: _____

_____

_____

Has your child had a Tetanus booster in the last 12 months? ☐ Yes ☐ No

Name of Doctor: _____ Phone No.: _____

Medicare Number: _____ Medicare Expiry Date: _____

Health Fund: _____ Membership No: _____

Any additional information you wish to advise us on:

_____

Name:_____Signature:_____ Date:_____

Please return the completed form to the OSHC Co-ordinator.