

Hart School of Dance

Student medical form



Name _____

Age _____

Does the student suffer from any of the following impairments? (Please tick)

Hearing Vision Speech Mobility

Does the student suffer from Asthma? YES NO

(If yes please fill out an asthma management form)

Other Medical Conditions:

Does the student have any other medical conditions YES NO

If YES please specify _____

Symptoms _____

If the student displays any of the above symptoms (please tick)

INFORM DOCTOR ADMINISTER MEDICATION INFORM EMERGENCY CONTACT

OTHER MEDICAL ACTION _____

Does the student take regular medication? _____

Is the medication taken by the student (preventative) or only in response to symptoms

PREVENTATIVE RESPONSE

Name of medication taken _____

Indicate the usual dosage of medication taken _____

Indicate how frequently the medication is taken _____

Medication is usually administered by... _____

Medication is stored _____ Dosage time _____

Reminder required? YES NO Poison Rating _____

Doctors Name _____

Individual or Group Practice? INDIVIDUAL GROUP

Number & Street or PO BOX NO _____

Suburb _____ State _____ Postcode _____

Telephone Number _____

Student Medicare Number _____

Does the student have Ambulance cover? _____

EMERGENCY CONTACTS:

1.

Name _____ Relationship _____

Home Number _____ Mobile _____

Work _____ After Hours _____

2. (Other than primary family contact)

Name _____ Relationship _____

Home Number _____ Mobile _____

Work _____ After Hours _____

Signed _____

Date _____

Printing your name here means you have agreed that are are agreeing with the Terms of Conditions on the Enrolment Form and adhering to school policy.