CHILD MEDICAL UPDATE FORM.

CHILD'S FULL NAME:.....

*Former Names ..... Any Other Names Known As .....

Customer Reference Number (CRN):.....(FROM THE DHS)

Home Address:.....

MALE / FEMALE (pls circle) DATE OF BIRTH:..... / ..... / .....

Does your child attend pre-school / school / other service (e.g. Long Day Care etc.): No ☐ Yes ☐

If yes, please indicate name of school / other service and days of attendance: .....

.....

Does the child have a disability (please tick): Learning & applying knowledge, education No ☐ Yes ☐

Communication No ☐ Yes ☐ Mobility No ☐ Yes ☐ Self Care No ☐ Yes ☐

Interpersonal interactions and relationships No ☐ Yes ☐ Other (including general tasks, domestic life, community and social life) No ☐ Yes ☐ If yes, please explain: .....

Does the child have additional needs (please tick): Children from culturally & linguistically diverse backgrounds No ☐ Yes ☐ Children with a refugee background who have been subjected to trauma No ☐ Yes ☐

The child's place has been sought by a state or territory child protection worker No ☐ Yes ☐

The child is in care of the state, or other forms of out of home care No ☐ Yes ☐

If yes, please explain: .....

COURT ORDER / PARENTING ORDER OR PLAN: (contact, residence, AVO etc.) No ☐ Yes ☐ If yes, please explain:.....

.....Please attach a copy of any orders relating to the child).

MEDICAL / ALLERGIES: Does the child have any allergies (please tick)? No ☐ Yes ☐ Explain .....

.....

Is there a medical action plan (please tick)? No ☐ Yes ☐ If NO, please describe .....

.....

If yes, attach a written copy of the medical action plan prior to care commencing supplied by a recognised medical practioner.

Does the child have any sensitivity (e.g. food, pollens, etc.) (please tick)? No ☐ Yes ☐ Explain .....

.....**If yes,** attach a medical action plan prior to care commencing.

Does the child have any medical conditions which are relevant to the children's service (e.g. asthma, epilepsy, diabetes etc.) (please tick)? No ☐ Yes ☐ Explain: …….

If yes, attach a written copy of the medical action plan prior to care commencing supplied by a recognised medical practioner.

Does the child have any dietary restrictions (please tick)? No ☐ Yes ☐ **If yes**, please provide a list of the restrictions in writing: ……

Is your child receiving any specialist medical attention or counselling? No ☐ Yes ☐ Explain ……

……

Doctor's/Counsellor's Name: ……

Is your child on regular medication? No ☐ Yes (please give details) ☐

DOCTOR:

NAME: ……

ADDRESS: ……

PHONE: …… HEALTH FUND NAME (if applicable): ……

MEDICARE NO: _ _ _ _ _ _ _ _ _ _ ☐ Number beside your child's name on card.

DENTIST:

NAME: ……

ADDRESS: ……

PHONE: ……

Parent / Guardian Name: ……

Signature: …… Date: ……

'This information is being collected with the principles of the Privacy and Personal Information Protection Act 1998 and accordingly will only be used for the purpose of which it is being collected.'

OFFICE USE ONLY: c.c EDUCATOR (name) …… COPIED BY (initial):…… DATE:……