WESTERN AUSTRALIAN
COLLEGE of AGRICULTURE
Morawa
An Independent Public School

MEDICAL CONSENT FORM

STUDENT FULL NAME_____

If for any reason your child needs medical treatment, the College will always endeavour to contact parents or guardians. This is not always possible due to parental commitments or the urgency of a medical situation.

Students aged 16 years or older will be left at the Medical Centre or Hospital unless parents request a staff member to be with them.

In this situation the staff of the College **must** have parental consent to seek medical treatment for a student. Attached is a Medical Consent Form that must be signed and returned on enrolment day.

If you have any concerns in signing this, please contact the College to discuss your concerns.

MORAWA MEDICAL CENTRE:

The Morawa Medical Centre requires your consent to collect personal information regarding students. This is for the primary purpose of providing quality health care. A full medical history is necessary for proper assessment, diagnosis and treatment. The information provided will also be used for Administrative and Billing purposes, including compliance with Medicare requirements. It may also be necessary to use this information for disclosure to others involved in student's health care, including doctors and specialists outside the medical practise. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to the practice following such referrals.
If the practice undertakes training of student doctors, or research activities, the following clauses may be adopted:

- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you **DO NOT** want student records accessed for these purposes.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to opt out.

MORAWA PHARMACY:

The following Terms and Conditions are in respect to the student whose details appear on this consent form:

1. The parent/guardian understands that Morawa Pharmacy adheres to Professional and Quality Care Pharmacy practice standards.
2. The parent/guardian understands and appreciates the fact that Morawa Pharmacy is bound by strict privacy rules. Therefore, any item bought from the pharmacy by the student, whether it is an over-the-counter item or a prescription item as well as any advice given to the student, is a matter of concern between the staff of the pharmacy and the student involved in the purchase **ONLY**. The pharmacy staff will **NOT** discuss the student's purchases to any third parties, including the parent/guardian, should any enquiries arise in relation to items appearing on the student's account. It is the duty and responsibility of the parent/guardian to discuss such issues directly with the student.
3. It is the Parent/Guardian responsibility to contact the Pharmacy to arrange an account facility.
4. Balances of accounts for the student mentioned in this document will be mailed out to the parent/guardian. The accounts will only show the cost of the item and **WILL NOT** include any detail or description about the items themselves.
5. It is the responsibility of the parent/guardian to make prompt payment of the account and the account needs to be settled within **14 days of the invoice date**.
6. By signing this document, the parent/guardian agrees to fully abide with the above mentioned terms and conditions and also allows the pharmacy to print out account balances to be mailed out.

CONTACT DETAILS:

MORAWA MEDICAL CENTRE - DR ADEBOLA ADEIYE
4 Caulfield Rd
MORAWA WA 6623

Ph: 9971 1103
Fax: 9971 1446

MORAWA PHARMACY
60 Winfield St
MORAWA WA 6623

Ph: 9971 1732
Fax: 9932 6120

PLEASE SEE OVER

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

I have read the attached information and understand why the collection of personal details is necessary. I am also aware the Morawa Medical Centre and Morawa Pharmacy both have a Privacy Policy on handling patient information.
I understand I am not obliged to provide any information requested, but that my failure to do so may compromise the quality of health care and treatment given.
I understand if personal information is to be used in any other way than set out in this document, I will be informed and further consent will be obtained.
I consent to the handling of personal information for the purposes set out in this document subject to any limitations on access or disclosure that I notify the Morawa Medical Centre of.

If for any reason _____ requires medical treatment, I hereby give my consent for the staff of WA College of Agriculture - Morawa to take him/her to the nearest doctor/hospital for whatever treatment is prescribed.

I understand that any costs incurred at either the Morawa Medical Centre or Morawa Pharmacy, are solely my responsibility.

PARENT/GUARDIAN: _____

SIGNATURE: _____

RELATIONSHIP TO THE CHILD: _____ DATE: _____

MEDICAL DETAILS

SURNAME: _____ GIVEN NAMES: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____ CONTACT NUMBER: _____

_____ _____

STUDENT PHONE NUMBER: _____

MEDICARE NUMBER: _____ STUDENT NUMBER ON CARD: _____

CARD EXPIRY DATE: _____

HEALTH CARE CARD: YES/NO CARD NUMBER: _____CARD EXPIRY DATE: _____

PRIVATE HEALTH INSURANCE: YES / NO AMBULANCE COVER: YES / NO

IF YES, WHICH FUND AND NUMBER: _____

DATE OF LAST TETANUS BOOSTER: _____

ALLERGIES:_____

_____

GLASSES/CONTACT LENSES:_____

MEDICAL HISTORY *(please include ADHD, Epilepsy etc.)*

_____

_____

LIST OF MEDICATIONS AND PURPOSE IF ANY

_____

_____

_____

STUDENT MEDICATION REQUEST

(FOR STUDENTS ON PRESCRIBED MEDICATION ONLY)

To be confidentially stored until the students is 25 years old.
This document to be destroyed in _____

NOTE: As the Principal of the College has approved of college staff administering or supervising the administration of medication to students, then the following requirements must be met.

The doctor prescribing the drug must be aware that the school will supervise or carry out administration of medication on the instructions provided. It is therefore necessary that the doctor provide instructions – as per Medication Instructions Form Prescribing Doctor. (See Appendix 2) These instructions are a mandatory requirement and are necessary when the school staff are to administer the drug, supervise the administration of the drug, or monitor the student after drug administration.

Drugs for administration should be delivered to the school into the care of a staff member. The school will prepare a student medication record and store the drugs in a secure place. All drugs should be contained in proper labelled containers showing the name of the drug, the name of the student and the appropriate dose and frequency.

(Please Print)
Name of parent/guardian _____

Name of student _____

Current School _____

Name of prescribing doctor _____

Medical condition being treated _____

Name of drug _____ Dose _____ Time to be taken _____

(It is the responsibility of the parent/guardian to provide the correct drug properly labelled. Improperly labelled drugs will not be administered).

Commencement date _____

Conclusion date _____

Replacement date of drug if appropriate _____

Note: 1 A new request/record agreement needs to be made

- If the dose or medication type is altered;
- If the regime is re-started following the expiration of this order;
- At the beginning of each new calendar year;
- If the designated teacher alters.

Note 2: This agreement form is only valid in conjunction with Appendix 2 of instructions form the prescribing doctor.

_____ _____

Parent Date Principal Date

PLEASE SEE OVER

To be confidentially stored until the student is 25 years old.
This document is to be destroyed in _____

Medication Instructions from Prescribing Doctor

These instructions are requested from the prescribing doctor to enable the school to maintain its 'duty of care' when administering prescribed drugs to students whose conditions would otherwise preclude attendance at school.

Dr _____

Address _____

Telephone _____

I have prescribed the drug _____

For (student name) _____ Date of Birth _____

To treat the condition of (name of medical condition) _____

This drug needs to be administered (dose) _____

(Frequency/time) _____

Are special arrangements necessary to administer the drug or monitor the student after administration?

Yes No (Please circle)

If so, provide details; _____

_____

_____

_____ _____
Signature of Prescribing Doctor Date

NON-PRESCRIPTION MEDICATIONS PERMISSION

I give permission for my daughter/son_____ to be given **PARACETAMOL** medications for minor aches and pains when deemed necessary.

Non Prescribed medications are **not** to be kept in student rooms, this includes but is not limited to items such as: cough syrups, herbal medications, iron tablets, Mylanta, Nurofen, Paracetamol. (Please see Residential Staff)

Name of Medication	***Dose***	***Frequency or as Required***	***Duration***	***By self or requires assistance***