CAMP LA SALLE: SYDNEY

MEDICAL INFORMATION FORM

(To be completed by Parent or Guardian)

Please return to your child's Year Coordinator. Lasallian Mission Services will retain it in confidence.

Participant's Name: _____ Date of Birth: _____

Gender: _____

Address: _____

Associated School: _____ Year Level: _____

Participant Contact Email Address _____

Parent Contact Email Address

_____

Mother / Guardian Name: _____

Home Telephone: _____

Work Telephone: _____ Mobile: _____

Father / Guardian Name: _____

Home Telephone: _____

Work Telephone: _____ Mobile: _____

Emergency Contact Name: _____

(Not parents)

Relationship to Participant: _____

Home Telephone: _____

Work Telephone: _____ Mobile: _____

Medicare Number: _____ **Expiry Date:** _____

Doctor's Name: _____ Telephone: _____

Specialist's Name: _____ Telephone: _____
(if applicable)

Ambulance Subscription? Yes[ ] No [ ] Part of Private Ins Yes[ ] No [ ]
(Highly Recommended)

My child can swim 50 metres:

No	[ ]
With a struggle	[ ]
Comfortably	[ ]
Strongly	[ ]

Details of any SPECIAL DIETARY CONDITIONS

_____

_____

Details of any KNOWN ALLERGIES, which your child has experienced

_____

_____

MEDICAL HISTORY

Has your child ever suffered from any of the following illnesses? Attach a management plan for any that you deem necessary. (Please tick the relevant boxes)

Fits of any type	☐	*Sleep Walking*	☐
Migraines	☐	*Travel Sickness*	☐
Heart Condition	☐	*Dizzy Spells*	☐
Blackouts	☐	*Diabetes (Complete plan)*	☐
Asthma (Complete plan)	☐	*Anaphylaxis (Complete plan)*	☐

OTHER MEDICATION

Is your son/daughter supplied with any medication, which he/she will need to take while away? Please attach any further details.

Yes [ ] No [ ]

Name/dosage/details: _____

_____

_____

Any other issues that you would like to note: _____

_____

_____

Parent / Guardian Consent

I declare that the information which I have provided on this form is complete and correct, and that I will notify Lasallian Mission Services if any changes occur prior to the Camp departure. I/We hereby give consent for _____to attend **Camp La Salle: Sydney 2016** and believe he/she is medically and physically fit to do so.

Lasallian Mission Services provides limited personal accident insurance cover for all participants while at Camp or travelling directly to and from Camp. By law, the cover can not apply to any Medicare service or Medicare gap.

Consent For Medical Attention		
Do you give permission for your child to attend the nominated program?	YES ☐	NO ☐
Do you authorise staff to dispense the above medication to your child at the prescribed times?	YES ☐	NO ☐
Do you give permission for your child to be given S2 analgesics, such as paracetamol?	YES ☐	NO ☐
Do you give permission for staff to administer first aid treatment as reasonably required?	YES ☐	NO ☐
Is your child's tetanus vaccination up to date? Date of vaccination: _____	YES ☐	NO ☐
Do you consent for ambulance, dental, medical or surgical treatment as deemed necessary in the event that you are unable to be contacted? Do you also agree to meet any associated costs?	YES ☐	NO ☐

I understand that Lasallian Mission Services needs to collect information about my son or daughter for the purpose of preparing for this event to ensure the safe environment is established, and that they will not pass my information on to any other organisation.

I consent to these details being used by Lasallian Mission Services for the promotion of other events and resources via post, phone, email, SMS, Facebook and other Social Media networks. I also understand that this event will be captured in photographs and video, and I consent for Lasallian Mission Services to use these for promotional and reporting purposes and other forms of communication.

Name (Printed) _____

Signature _____

Date _____

Asthma First Aid

1 Sit the person upright

— Be calm and reassuring
— Do not leave them alone

2 Give 4 puffs of blue reliever puffer medication

— Use a spacer if there is one
— **Shake** puffer
— Put **1 puff** into spacer
— Take **4 breaths** from spacer

Repeat until **4 puffs** have been taken

Remember: Shake, 1 puff, 4 breaths

3 Wait 4 minutes

— If there is no improvement, give **4 more puffs** as above

4 If there is still no improvement call emergency assistance (DIAL 000)*

— Say 'ambulance' and that someone is having an asthma attack
— Keep giving **4 puffs** every **4 minutes** until emergency assistance arrives

*If calling Triple Zero (000) does not work on your mobile phone, try 112

Call emergency assistance immediately (DIAL 000)

— If the person is not breathing
— If the person's asthma suddenly becomes worse, or is not improving
— If the person is having an asthma attack and a puffer is not available
— If you are not sure if it's asthma

Blue reliever medication is unlikely to harm, even if the person does not have asthma

Asthma Australia

To find out more contact your local Asthma Foundation
1800 ASTHMA (1800 278 462) | **asthmaaustralia.org.au**

 Supported by the Australian Government

Translating and Interpreting Service 131 450

Asthma care plan for schools

CONFIDENTIAL: Staff are trained in asthma first aid (see overleaf) and can provide routine asthma medication as authorised in this care plan by the treating doctor. Please advise staff in writing of any changes to this plan.

To be completed by the treating doctor and parent/guardian, for supervising staff and emergency medical personnel.

PLEASE PRINT CLEARLY

Asthma Australia

Photo of student

(optional)

Student's name:

Date of birth:

Managing an asthma attack

Staff are trained in asthma first aid (see overleaf). Please write down anything different this student might need if they have an asthma attack:

Daily asthma management

This student's usual asthma signs

- ☐ Cough
- ☐ Wheeze
- ☐ Difficulty breathing

Other (please describe)

Frequency and severity

- ☐ Daily/most days
- ☐ Frequently (more than 5 x per year)
- ☐ Occasionally (less than 5 x per year)

Other (please detail)

Known triggers for this student's asthma (eg exercise*, colds/flu, smoke) — please detail:

Does this student usually tell an adult if s/he is having trouble breathing?	☐ Yes	☐ No
Does this student need help to take asthma medication?	☐ Yes	☐ No
Does this student use a mask with a spacer?	☐ Yes	☐ No
*Does this student need their blue reliever puffer medication before exercise?	☐ Yes	☐ No

Medication Plan —

If this student needs asthma medication, please detail below and make sure the medication and spacer/mask are supplied to staff.

Name of medication and colour	*Dose/number of puffs*	*Time required*

Name of doctor

Address

Phone

Signature Date / /

Parent/guardian

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.

Name

Signature

Date / /

AA AF School Careplan 0113

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline autoinjectors

Name: _____
Date of birth: _____

Photo

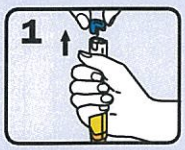
Confirmed allergens:
_____
_____
_____

Family/emergency contact name(s):
_____
_____

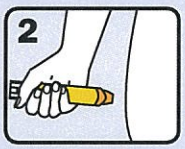
Work Ph: _____
Home Ph: _____
Mobile Ph: _____

Plan prepared by:
Dr: _____
Signed: _____
Date: _____

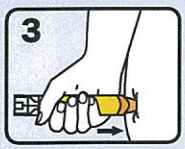
How to give EpiPen®



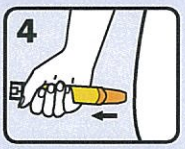
Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE.



PLACE ORANGE END against outer mid-thigh (with or without clothing).



PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds.



REMOVE EpiPen®. Massage injection site for 10 seconds.

Instructions are also on the device label and at www.allergy.org.au/health-professionals/anaphylaxis-resources

MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

ACTION

- **For insect allergy, flick out sting if visible. Do not remove ticks**
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr
- Give other medications (if prescribed) .....
  Dose: .....
- Phone family/emergency contact

Mild to moderate allergic reactions may or may not precede anaphylaxis

Watch for any one of the following signs of Anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

ACTION

1 Lay person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.
2 Give EpiPen® or EpiPen® Jr
3 Phone ambulance*- 000 (AU), 111 (NZ), 112 (mobile)
4 Phone family/emergency contact
5 Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)

If in doubt, give adrenaline autoinjector

After giving adrenaline:
- **Commence CPR if there are no signs of life**
- **Give asthma medication if unsure whether it is asthma or anaphylaxis**

EpiPen® is generally prescribed for adults and children over 5 years.
EpiPen® Jr is generally prescribed for children aged 1-5 years.
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

Additional information _____

Note: This is a medical document that can only be completed and signed by the patient's treating medical doctor and cannot be altered without their permission.