

Lismore Heights Public School
HEALTH DETAILS RECORD
CONFIDENTIAL

NAME OF STUDENT:	
ADDRESS:	
PHONE NO:	DATE OF BIRTH:
MOTHER: WORK PHONE NO:	FATHER: WORK PHONE NO:
EMERGENCY CONTACT NAME: PHONE NO: RELATIONSHIP TO CHILD:	
ALLERGIES: Detail any allergies that may cause severe reactions or distress eg, penicillin, bee stings, peanut intolerance, etc.	
ILLNESS: Describe any sickness your child may have had recently which may affect their participation (including Asthma).	
MEDICATION: Does your child take any special course of tablets or medicine which we would need to monitor?	
FOOD: Describe any special dietary needs due to allergies, vegetarian diet, etc.	
DATE OF LAST TETANUS INJECTION:	DOES YOUR CHILD SUFFER FROM TRAVEL SICKNESS? YES <input type="checkbox"/> NO <input type="checkbox"/>
FURTHER INFORMATION you think is relevant to your child's well-being: (e.g. bed wetting, sleep walking etc.)	
MEDICARE NO:	HEALTH FUND