



# ST PATRICK'S PRIMARY SCHOOL

Patrick St Stawell

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## ADULT MEDICAL FORM

Excursion: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: Business: \_\_\_\_\_ Home: \_\_\_\_\_

Emergency Contact No: \_\_\_\_\_

Name/Phone No of Family Doctor: \_\_\_\_\_

Medical Insurance Fund: \_\_\_\_\_

Member No: \_\_\_\_\_ Medicare No: \_\_\_\_\_

Ambulance Membership: YES/NO

Do you suffer from any of the following:

- Migraine                       Heart problems  
 Blood Pressure               Other medical disorder \_\_\_\_\_

Asthma – if yes, medication to be taken during an attack:  
\_\_\_\_\_

Expected Best Peak Flow Expiratory Flow reading \_\_\_\_\_/min.

Flow reading requiring extra medication \_\_\_\_\_/min.

Flow reading contact doctor/hospital \_\_\_\_\_/min.

Do you have any medical disorders/allergies that our first aid person should be aware of?

Medication: \_\_\_\_\_

I authorise the teacher in charge of the excursion/camp to consent, where I am unable, to my receiving such medical or surgical treatment as may be deemed necessary. I accept all operation, blood transfusion and/or anaesthetic risks involved and the responsibility for payment of any expenses incurred.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_