



## External Student Medical Form

RTO No. 45550

Riverside Christian College RTO offers many Vocational Education and Training (VET) Qualifications and require the student to attend campus or our school farm. As the Supervisor/Parent/Guardian of a student, you are required to complete and submit all sections of this form prior to the student attending Riverside Christian College Campus or School Farm.

Student Information					
First Name:		Middle Name:		Surname:	
Residential Address:					
Date of Birth:		Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Mobile:		Home Ph:			
Supervisor/Parent/Guardian Name:		Mobile:			
Supervisor/Parent/Guardian Name:		Mobile:			
Emergency Contact No 1 Details (if supervisor/parent/guardian's listed are unavailable)					
Name:		Mobile:			
Relationship to Student		Home Ph:			
Emergency Contact No 2 Details (if supervisor/parent/guardian's listed are unavailable)					
Name:		Mobile:			
Relationship to Student		Home Ph:			
Medical Practitioner/Medicare/Private Health Details					
Medical Practitioner's Name:		Contact Number:			
Medicare Number:		Students Number on Medicare Card:			



Medical Conditions (if Yes is ticked, please provide more information in the space provided)			
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Indicate the cause and extent of the reaction
			Please provide a copy of Allergy Reaction Plan
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide a copy of Asthma Management Plan
Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Blood Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Ear/Hearing problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Eczema/Skin conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Epilepsy/Convulsions/Fits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Eye/Sight problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Migraines/Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Physical disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Other Illnesses or existing injuries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Any other medical condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details
Any other diagnosis in place	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please provide details





**RIVERSIDE**  
CHRISTIAN COLLEGE

Any Medication Required while attending our Campus?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medication Name and Dosage:		Relevant details:	
<b>Other Current Medication</b>			
Medication Name and Dosage:		Relevant details:	

Medical Authority	
In Case of Emergency, I grant the person in charge, authority to seek any necessary medical assistance and/or treatment. I give permission to the person in charge, to administer <b>the supplied emergency medication (if supplied)</b> , if I am unable to do so myself. By submitting this form, I declare that the information provided herein, is complete and correct.	
Supervisor/Parent/Guardian Name	
Supervisor/Parent/Guardian Signature	
Date	

### RTO Manager Contact Details

Bronte Hose

[Bronte.hose@riverside.qld.edu.au](mailto:Bronte.hose@riverside.qld.edu.au)

(07) 4123 1031



## MEDICATION ORDER FORM (Doctor / GP)

**RIVERSIDE**  
CHRISTIAN COLLEGE

**Privacy Statement:** Riverside collects the information contained in this form to administer medications for students. The information collected will be held at Riverside Christian College and will only be made available to authorised staff of the school and to medical or paramedical staff in the case of an accident or emergency. The information contained in the form is personal information and it will be stored, used and disclosed in accordance with the requirements of the *Information Privacy Act 2009 (Cwth)*.

This form is a record of Doctor/Practitioner's medication order for the administration of medication.

\*\*\*To be completed by Medical Practitioner\*\*\*

### Section 1 – Details of medication to be administered by school staff (Parent/Carer to complete)

<b>Student Name</b>		<b>Date of birth</b>	
<b>Parent/s Name</b>		<b>Phone number</b>	
<b>Sex</b>		<b>Known Allergies / Drug Reactions</b>	

<b>Practice Name</b>	
<b>Practitioner Name</b>	
<b>Practitioner Address</b>	
<b>Practitioner Contact Number</b>	

"Prescriber Stamp"

### SHORT-TERM ROUTINE MEDICATION (e.g. Antibiotics)

Date to Commence	Medication Name	Route	Dose/Strength	Administration times/ Frequency	Indication	Date of last dose

### LONG-TERM ROUTINE MEDICATION (e.g. Ritalin)

Date to Commence	Medication Name	Route	Dose/Strength	Administration times/ Frequency	Indication	Admin Notes

### NON-ROUTINE MEDICATION (e.g. Antihistamines)

Order Date	Medication Name	Route	Dose/Strength	Administration times/ Frequency	Indication	Max Dose in 24 hours

See attached prescriber notes/letter

See attached asthma/allergy action plan

<b>Practitioner Signature</b>	
<b>Date</b>	

## MEDICATION ADMINISTRATION FORM

**Privacy Statement:** Riverside collects the information contained in this form to provide or arrange first aid and other medical treatments for students. The information collected will be held at Riverside Christian College and will only be made available to authorised staff of the school and to medical or paramedical staff in the case of an accident or emergency. The information contained in the form is personal information and it will be stored, used and disclosed in accordance with the requirements of the *Information Privacy Act 2009 (Cwth)*.

This form is a record of a parent/carer's request for the College to administer medication to their child.

A separate form is required for additional medications.

Changes in medication and/or dosage will require the completion of a new form.



**RIVERSIDE**  
CHRISTIAN COLLEGE

Section 1 – Details of medication to be administered by school staff (Parent/Carer to complete)				Insert student photo below.
<b>Student name</b>			<b>Date of birth</b>	
<b>Parent/carer name</b>			<b>Contact phone number</b>	
<b>Prescribing Practitioner &amp; Address</b>				
<b>Name of medication</b>	<b>Dosage (e.g. 1 tablet)</b>	<b>Strength (e.g. 10mg)</b>	<b>Expiry Date</b>	
<b>This medication is: - (tick and complete one section only)</b>				
<input type="checkbox"/>	<b>SHORT-TERM ROUTINE MEDICATION</b> (e.g. antibiotics)	<i>Medical Condition</i>	<i>Date duration for medication</i>	<i>Time/s to be given during school</i>
<input type="checkbox"/>	<b>LONG-TERM ROUTINE MEDICATION</b> (e.g. Ritalin)	<i>Medical Condition</i>	<i>Start date for medication</i>	<i>Time/s to be given during school</i>
<input type="checkbox"/>	<b>NON-ROUTINE MEDICATION</b> (e.g. antihistamines)	<i>Symptoms for which medication should be given</i>		<i>Other conditions or comments</i>
<b>Additional information</b>				
<input type="checkbox"/>	Written authorisation from a medical practitioner is attached (MANDATORY)			
<input type="checkbox"/>	The medication provided is in its original packaging with a pharmacy label matching the information included in this form (MANDATORY)			
<input type="checkbox"/>	This is Emergency medication and an Action Plan signed by a medical practitioner is attached			
<b>Parent/carer signature</b>			<b>Date:</b>	

