

# Maroon OEC STUDENT INFORMATION

**Name:**

**Sex:**

**Year:**

**PLEASE ENSURE THAT YOU COMPLETE THE MEDICAL INFORMATION FORMS ACCURATELY**

**MEDICAL CONDITIONS:**

ASTHMA	YES	NO	If YES, please complete an Asthma Management Form
ALLERGIES (other than food)	YES	NO	If YES, please complete an Allergy Management Form
DIABETES	YES	NO	If YES, please complete a Medical Management Form
EPILEPSY	YES	NO	If YES, please complete a Medical Management Form
HEART/CIRCULATION ISSUES	YES	NO	If YES, please complete a Medical Management Form

**OTHER ISSUES TO BE CONSIDERED FOR YOUR CHILD:**

<input type="checkbox"/> ADD / ADHD*	<input type="checkbox"/> ASD*	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety*	<input type="checkbox"/> Physical Impairment*	<input type="checkbox"/> Sleep related conditions
<input type="checkbox"/> Recent operations	<input type="checkbox"/> Phobias	<input type="checkbox"/> Intellectual Impairment*
<input type="checkbox"/> Existing Injury *	<input type="checkbox"/> Previous Injury*	<input type="checkbox"/> Other

**DETAILS OF MEDICAL ISSUES (*Leave blank if none*):**

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*\*Please complete a Support Management Form if additional support or reasonable adjustments are required*

**LIST ANY MEDICATION BEING TAKEN BY YOUR SON/DAUGHTER (*Leave blank if none*)**

Drug Name	Dosage	Frequency	Condition or Doctors Instructions

*\* FOR ANY MEDICATION, PLEASE COMPLETE A MEDICAL MANAGEMENT FORM*

**DIETARY REQUIREMENTS - List any foods not to be eaten (*Leave blank if none*):**

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**Indicate the reason (Check all that apply)**

Anaphylaxis	Severe Reaction or Intolerance	Mild Reaction or Intolerance	Religious or Cultural	Food Preference
<input type="checkbox"/> *	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*\* IF TICKED, PLEASE COMPLETE A DIETARY MANAGEMENT FORM*

**SWIMMING ABILITY:**                      Non Swimmer                      25m                      50m                      100m

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