

# Marsden State High School



## Health Registration Form (GP)

### Name

First name:	Last Name:
Preferred Name:	Date of Birth: ___/___/___
Gender: ___ Male ___ Female ___ Other (please specify) _____	School Year/ Grade
Mobil Number (If you are 16+ years):	

### Contact Details

Home Address:	
Number and Street name:	
Suburb:	Postcode

### Parent/carer information

Parent 1:

Name:
Mobil Number:
Email:

Parent 2:

Name:
Mobil Number:
Email

Are there any custody issues we need to be aware of (please describe)

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Emergency contact person (if different to parent/carer)

Name:
Relationship to you
Mobile

### Medicare Details

Medicare Number: _____/___
Number next to your name:
Medicare Card Expiry Date: ___/___/___

**Health Care/Concession Card Details (if you have one)**

Health Care/Concession Care Number:
Health Care/Concession Care expiry date: ___/___/___

**OSHC Card number**

Number next to your name: _____/___
Medicare card expiry date: ___/___/___
Fund:

**Do you identify as Aboriginal or Torres Strait Islander (please tick)**

<input type="checkbox"/> Yes Aboriginal	<input type="checkbox"/> Yes Torres Strait Islander	<input type="checkbox"/> Yes Both	<input type="checkbox"/> No neither
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**Country of birth**

What is your country of birth? _____	Is an interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No Preferred Language _____
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**Do you have a regular GP or family doctor?**

Name of Doctor:	Name of clinic:
Do you want a copy of today's appointment sent to your regular GP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any medical problem that you are aware of? _____	
Do you have any allergies? _____	
Please list any medication your take (including over the counter/ vitamins etc.) _____ _____	

**Immunisations (Please tick)**

	Yes	No	Don't Know
Routine childhood immunisations			
Gardasil (HPV)			
Booster dose of Tetanus?			
Booster dose of Diphtheria?			
Influenza			
MenACWY			
MenB			

