Medical Information Form

Student's Name: ______________________________

(This information will be filed in the Health Centre)

1. Family Medical Centre: ______________________________

Address: ______________________________

Doctors Name: ______________________________

Phone: ______________________________

My child has or has had the following disabilities, allergies or medical problems which may affect his / her performance or activities at school.

2. Allergic Reaction to:		**Specify Type**
Nil Known	☐	
Bee / Wasp stings	Yes	____________
Medication e.g. Penicillin	Yes	____________
Food e.g. Peanuts	Yes	____________
Other	Yes	____________

3. Medical Condition		**Medication required (see below) – other details**
Asthma (see section 9)	Yes	____________
ADHD / Behaviour Problems	Yes	____________
Epilepsy	Yes	____________
Rheumatic Fever	Yes	____________
Hepatitis A or B / HIV	Yes	____________
Glandular Fever	Yes	____________
Migraines / Headaches	Yes	____________
Heart Conditions	Yes	____________
Tuberculosis Yes		____________
Nose Bleeds	Yes	____________
Recurring Abdominal Pains	Yes	____________
Back / Neck Problems	Yes	____________
Past illness or operations	Yes	____________
Nil	Yes	____________

Has your son / daughter been hospitalised for an operation, illness or accident – if yes, state details

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4. Medicatio ns:

Please send **labelled** medication to the Student Services Reception if it is required for regular use or for emergencies e.g. antihistamine for bee stings.

5. Does your son / daughter have any medication on a regular basis?

a) Any medication not mentioned above? Yes / No

b) A course of treatment / counselling? Yes / No

If yes, please detail: ______________________________

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6. Does your child have any metal implants of any kind, eg. Surgical plates or bone support structures? (This information is essential in the event the child should need an MRI) NO/YES

Details: ______________________________

7. Immuni sations:

Has your son / daughter had the following immunizations? (circle answer)

Tuberculosis (BBG)	Yes / No	Tetanus	Yes / No
MMR (Measles/ Mumps/Rubella)	Yes / No	Hepatitis	Yes / No

8**. Sensory Loss: Yes / No**

If yes, please specify type and degree below:

Visual	Right	______	Left	______	Bilateral	______	Amount (e.g. mild, 100%)	______
Hearing	Right	______	Left	______	Bilateral	______	Amount (e.g. mild, 100%)	______

Devise used? (e.g. Glasses / hearing aid) ______________________________

8. Other Relevant Conditions: Yes / No

If yes, please detail: ______________________________

9. Asthma Sufferers only:

Does your child have an "Asthma Action Plan"? Yes / No

If yes, please copy for Student Services

If using preventers, the Asthma Society recommends having an action plan (requires updating every 6-12 months). See your GP / Practice Nurse.

10. Minor Ailments: (e.g. Headaches)

Do you authorise the school office / Student Services to provide medication (e.g. Panadol, Disprin etc)

Yes / No Signed: ______________________ Date: ______________________

IN CASE OF ACCIDENT OR EMERGENCY:

In case of accident or emergency and the school cannot contact you, or if the accident is serious, the School may arrange for your child to be taken to Accident and Emergency.

I give permission for the school to make the necessary arrangements for the treatment of my child in an emergency and agree to meet any costs incurred.

Parent / Guardian Signature:______________ Date: ________________

Family circumstances and a student's health may change in the course of a year. The more up-to-date information we have, the better we are able to treat your son/daughter should it be necessary. It would be very helpful if the school could be notified as soon as possible by a note or e-mail to the Whanau House Leader or School Nurse.

We must have up-to-date contact phone numbers in case of emergency