WAIROA COLLEGE HEALTH INFORMATION

DOCTOR SURGERY NAME: _____

Phone number: _____

Student's Name: _____

Address: _____ Date of Birth: _____

_____ Phone number: _____

1. ALTERNATIVE CONTACT FOR EMERGENCIES:

Name: _____

Relationship: _____ Phone number: _____

2. MEDICAL CONDITIONS

In order to maintain our records and help us care for your child in an illness/emergency situation, could you please answer the following questions. For the safety of your child, parts of this information may need to be shared with other school staff.

Has your child ever had any of the following?

Rheumatic Fever	yes/no	A Heart Condition	yes/no
Diabetes	yes/no	Epilepsy	yes/no
Hepatitis A, B or C	yes/no	Asthma	yes/no
HIV/AIDS	yes/no	Migraines/Headaches	yes/no

Any other Medical Conditions: _____

_____

_____

3. ALLERGIC REACTION

Bee/wasp stings	yes/no	Medication	yes/no
Food	yes/no	Other	yes/no

Detail if required _____

4. MEDICATIONS

Please give details of any regular medication your child is on.

Medication _____ What for? _____

Dose _____ How often? _____

Please send labelled medication to the school office if it is required for regular use or for emergencies such as antihistamines for bee stings.

Please send a copy of your child's asthma plan if they are on one.

I give permission for the School based Nurse or the School First Aid officers to give my child the following medication if he/she requires it.

Paracetamol / Ibuprofen YES / NO PLEASE CIRCLE

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5. IMMUNISATION HISTORY

– a copy of the immunisation history must be sighted and held on record.

Age	Diseases covered and Vaccines	Please confirm [YES] if your child is immunised
6 weeks	Diphtheria/Tetanus/Whooping Cough/Polio/Hepatitis B/Haemophilus influenzae type b - 1 injection Pneumococcal - 1 injection	
3 months	Diphtheria/Tetanus/Whooping Cough/Polio/Hepatitis B/Haemophilus influenzae type b - 1 injection Pneumococcal 1 injection	
5 months	Diphtheria/Tetanus/Whooping Cough/Polio/Hepatitis B/Haemophilus influenzae type b - 1 injection Pneumococcal - 1 injection	
15 months	Haemophilus influenzae type b - 1 injection Measles/Mumps/Rubella - 1 injection Pneumococcal - 1 injection	
4 years	Diphtheria/Tetanus/Whooping Cough/Polio - 1 injection Measles/Mumps/Rubella - 1 injection	
11 years	Diphtheria/Tetanus/Whooping Cough 1 injection	
12 years **girls only**	Human Papillomavirus ** - 3 doses given over 6 months	

Immunisation record sighted **Staff signature:** _____

6. HEALTH CHECK

- I give permission for the School based Nurse to give my child a health check – this will include measuring height and weight, checking hearing, vision and blood pressure, plus a discussion on nutrition, exercise, physical, emotional, sexual health and hygiene. *(Parents will be notified if necessary and are welcome to contact the nurse with any queries).*

YES / NO **PLEASE CIRCLE**

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____