Alfriston College International Medical Form

To assist our School Health Centre in providing the best possible care for your child in any illness / emergency situation, please answer the following. While this information is strictly confidential, it may be necessary for the safety of your child and others, to inform relevant staff of medical conditions. This Medical Form will be filed in the School Health Centre. The school realises that family circumstances and a student's health may change in the course of their schooling. It would be very much appreciated if the school is notified as soon as possible by either:

a) A phone call to the Health Centre on +64 9 269-0080 Ext 810
b) A phone call to the Main Office on +64 9 269-0080 Ext 800.

STUDENT'S NAME:_____ **Date of Birth:**_____

Family Doctor:_____ Phone Number:_____

Family Dentist:_____ Phone Number:_____

1 MEDICAL CONDITIONS

My child has the following medical conditions which may affect his/her performance at school.

Medical Condition	**Circle**	**Medication / Details**	**Is there a Family History of:**	**Circle**
Asthma	Yes/No		Asthma	Yes/No
Diabetes	Yes/No		Diabetes	Yes/No
Epilepsy	Yes/No		Epilepsy	Yes/No
Rheumatic Fever	Yes/No		Stroke/high blood pressure	Yes/No
Hepatitis A /B / HIV	Yes/No		Heart Condition	Yes/No
Glandular Fever	Yes/No		Tuberculosis	Yes/No
Migraines / Headaches	Yes/No		**Details:**	
Heart Condition	Yes/No			
Tuberculosis	Yes/No			
Nose Bleeds	Yes/No			
Back / Neck Problems	Yes/No			
Past Illness / Operations	Yes/No			
Eating Disorder	Yes/No			
Depression/Anxiety	Yes/No			
ADD or ADHD	Yes/No			
Other (Please Specify)	Yes/No			

2 ALLERGIES

Allergic Reaction to	**Please circle**	**Reaction and Treatment**
Bee / wasps stings	No / Mild / Medium / Severe	
Medication	No / Mild / Medium / Severe	
Food	No / Mild / Medium / Severe	
Other (Please Specify)	No / Mild / Medium / Severe	

3 MEDICATIONS

Please send labelled medication to the School Nurse if it is required for regular use or for emergencies, such as antihistamines for bee stings or inhalers for asthma.

Does your child have on a regular basis?

a) Any medication not mentioned above? Yes / No
b) A course of treatment / counselling? Yes / No

If Yes, please detail_____

4 IMMUNISATIONS:

Has your child had the following immunisations? (Circle answer)

MMR (Measles/Mumps/Rubella)	Yes/No	Meningococcal B	Yes/No
Tuberculosis	Yes/No	Tetanus	Yes/No
Hepatitis	Yes/No	Cervical Cancer	Yes/No

5 HEARING LOSS

Does your child suffer from any hearing loss? Yes /No

Wears hearing aids Yes/No

6 EYESIGHT

Wears glasses Yes/No

7 ASTHMA SUFFERERS ONLY

Does your child have an'ASTHMA ACTION PLAN'? Yes/No

If YES, please attach.

If using preventers, the Asthma Society recommends having an Action Plan, which requires updating every 6 – 12 months. See your doctor or practice nurse.

PERMISSION FOR ADMINISTERING MEDICATION

(eg Panadol, Mylanta, topical creams, Nurofen, Mylanta). In some circumstances it is necessary for medication to be given for such things as headaches, period cramps, and colds.
I give permission for the School Nurse to administer this treatment if necessary:

Parent/ Guardian Signature: _____ Date: _____

IN CASE OF ACCIDENT OR EMERGENCY:

In case of an accident or emergency and the school cannot contact you, or if the accident is serious, the School Nurse 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: _____

In case of a serious accident or emergency, an ambulance will be called. A parent / guardian will also be called.