Alfriston College 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 learner'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 telephone to Student Services on 269-0080 Ext 900 or by email to s.nurse@alfristoncollege.school.nz

LEARNER'S NAME _____ **Date of Birth** _____

NHI (From Family Dr) Hospital Number from Plunket Book _____

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		Meningococcal Disease	Yes/No
Heart Condition	Yes/No		Rheumatic Fever	Yes/No
Tuberculosis	Yes/No		**Details:**	
Nose Bleeds	Yes/No			
Back / Neck Problems	Yes/No			
Past Illness / Operations	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 complete a 'request for the College to administer medication to a learner' form (available at Main Reception) and 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_____

_____

Student ID _____

Start Date _____

Year Level _____

Entered Kamar _____

Entered Pupil Web Y / N

Whānau _____

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

Other Vaccines

5 HEARING LOSS

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

Wears hearing aids Yes/No

If Yes – please give details _____

As part of Year 9 Health screening Deaf and Hard of Hearing will be attending Alfriston College. If you do **NOT** wish for your child to be screened, please contact the School Health Centre on **s.nurse@alfristoncollege.school.nz**

6 EYESIGHT

Has glasses Yes/No Wears glasses Yes/No

7 SPECIAL HOME CIRCUMSTANCES

Are there any factors that may affect your child's behaviour or emotional stability? Yes/ No

If Yes – please give details_____

_____

8 ASTHMA SUFFERERS ONLY

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

If YES, please give a copy to the School Nurse.
If using preventers, the Asthma Society recommends having an Action Plan, which requires updating every 6 – 12 months. See your doctor or practice nurse.

9 HEALTH ASSESSMENT

If you do **NOT** wish your child to participate in a Health and Wellbeing Assessment please contact the school Health Centre on s.nurse@alfristoncollege.school.nz.

10 DENTAL

If you do **NOT** wish for your child to be enrolled into **THE TOOTH GROUP** at Alfriston College please contact the School Health Centre on **s.nurse@alfristoncollege.school.nz.**

PERMISSION FOR ADMINISTERING MEDICATION

(e.g. Panadol, Mylanta, topical creams, Nurofen, Antihistamine or other over the counter medication). In some circumstances it is necessary for medication to be given for such things as headaches, period cramps, allergies and colds and any medication required in an emergency e.g. adrenaline.

I give permission for the School Nurse to administer this treatment if necessary.

Parent/ Caregiver 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 by ambulance to Accident and Emergency or arrange consultation with the school physiotherapist at no charge if accident related. **In an emergency/accident a parent/caregiver will be called, so please ensure the school has your most current contact details**

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/Caregiver Signature _____ Date _____