

# 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](mailto: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 |                      | <b>Details:</b>              |        |
| 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](mailto: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](mailto: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](mailto: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 \_\_\_\_\_