Student Health Record *(Confidential)*

To help maintain records for the Health Department, and to help us care for your son in any illness/emergency situation, could you please answer the following questions.

Please contact the School Nurse with any serious health issues prior to your son starting.

STUDENTS SURNAME ____________________ **FIRST NAME** ____________________

EMERGENCY PHONE ____________________

FAMILY DOCTORS NAME and PHONE NUMBER ____________________

Does your son have or ever suffered from:		**If yes please provide detailed relevant information**
Asthma	Yes/No	____________
Diabetes	Yes/No	____________
Epilepsy	Yes/No	____________
Rheumatic Fever	Yes/No	____________
Hepatitis A,B or C or HIV/AIDS	Yes/No	____________
Glandular Fever	Yes/No	____________
Tuberculosis	Yes/No	____________
Attention Deficit	Yes/No	____________
Ear Ache or Ear Problems	Yes/No	____________
Allergic Reaction to Stings	Yes/No	____________
Allergic Reaction to Food	Yes/No	____________
Allergic Reaction to Medication	Yes/No	____________
Other Allergic Reactions (please state)	Yes/No	____________
Concussion	Yes/No	____________
Poor Eye Sight	Yes/No	____________
Migraine Headaches	Yes/No	____________
Any Other Medical Condition	State	____________

Has your son had the following vaccination?		**YEAR OF VACCINATION**
Tetanus	Yes/No	____________
Hepatitis (Hep B)	Yes/No	____________
Tuberculosis (BCG)	Yes/No	____________
Measles/Mumps/Rubella (MMR)	Yes/No	____________
Meningococcal B	Yes/No	____________

Accident or Emergency Situations: If the School is unable to contact you due to an accident or emergency the School Nurse may send your son to a Medical Centre or to Waitakere Hospital A&E Department by ambulance, if necessary.

I give my permission for the School Nurse to make such arrangements and I will meet the costs incurred.

Non Prescription Medicines: I give permission for the School Nurse to administer non prescription medicines such as Aspirin, Panadol, Mylanta, Throat Lozenges, Antihistamines, Magnesium, Paracetamol, Vitamin C.

Asthma: I authorise the school to administer asthma medication when necessary.

Parent's / Caregiver signature ____________________ Date ____________

The School Nurse is available during normal school hours Monday to Friday.