TWIZEL AREA SCHOOL

Student Health Record

Family Name:_____ **Given Name(s):**_____

Date of Birth:_____/_____/_____

To assist us in providing the best possible care for your child in any illness/emergency situation, please complete the following questionnaire in as much detail as possible. 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 office. The school realises that family circumstances and a student's health may change during the course of their schooling. It would be very much appreciated if the school is notified as soon as possible by contacting the school office on (03) 435 0650.

Family Doctor:

Name: _____ Phone number: _____

Family Dentist:

Name: _____ Phone number: _____

Tick ✔	Condition	Medication	Action Plan (if required)
	Asthma		
	ADD or ADHD		
	Diabetes		
	Epilepsy		
	Headache/Migraine		
	Nose Bleeds		
	Heart Conditions		
	Hepatitis A/B/HIV		
	Previous Head Injury		
	Other (please specify)		
	Allergies (see below)		

Tick ✔	Allergy/Reaction	Tick ✔	Allergy/Reaction
	Anaesthetics		Hay fever
	Aspirin		Insect Bites
	Bee or Wasp Stings		Penicillin
	Codeine		Sunlight
	Food Allergy		Other (Please specify)

Immunisation Status:

Please attach a copy of your child's Immunisation Certificate from their Well Child/Plunket book or from your family GP/Practice Nurse.

Other medical or physical problems, including conditions that may limit particpation in Physical Education:

ASTHMA

Does your child have an ASTHMA ACTION PLAN? (Please circle) **Yes** **No**

If YES, Please hand a copy to the school office. If using preventers, the Asthma Society recommends having an Action Plan which requires updating every 6 to 12 months. See your Doctor or Practice Nurse.

MEDICATION

For those students who have a medical condition and require regular medication, it is advisable to leave a supply of their labelled medication with the school office e.g. Epi-Pen, Antihistamines for Allergies, Medication for Migraines, Insulin for Diabetes and an Inhaler for Asthma etc. Furthermore, please contact the office to discuss these requirements, and to obtain a copy of the Parental Consent Form which will allows the office staff to administer the prescribed medication.

Regular medication(s):

_____

_____

_____

HEARING

Does your child suffer from any hearing loss? (Please circle) **Yes** **No**
Does your child wear a hearing aid? (Please circle) **Yes** **No**
If the hearing loss is significant enough to affect their learning, please describe the ways in which your child is affected below:

_____

_____

EYESIGHT

Does your child suffer from any vision impairment or concerns? Yes No Does your child wear glasses? Yes No Does your child wear contact lenses? Yes No If the vision impairment is significant enough to affect their learning, please describe the ways in which your child is affected below:

_____

_____

Signature: _____ Date: _____

Extra Information: