HEALTH IN FORMATION

This information will be used by the nurses and only shared with others who need to know, for example, the Ambulance Service, Emergency Department or Public Health Nurses. If this information is to be passed on you will be notified as soon as possible.

If you are unsure about any of the questions or would like to discuss any of the following, please phone our Registered School Nurses, on 09 237 0195 DDI / 09 237 0117 ext 212.

A

Student's Name: _____ **Date of Birth:** _____

NHI Number (if known): _____ **Year Level:** _____

Name of person filling out this form:

Name: _____ Relationship to student: _____

B DOCTOR / DENTIST

Which **doctor / clinic** does the student go to?

_____ Ph: _____

Which **dentist** does the student go to?

_____ Ph: _____

C HEARING / VISION / SPEECH

Please describe any difficulty your student has with any of the following:

Hearing	Vision	Speech

D MEDICAL CONDITIONS

Medical Condition	Please circle		Comment
Asthma (trouble breathing)			If yes, what is the name of the medicine they take?
Do they have an inhaler?	Yes	No	
Do they have an Asthma Action Plan?	Yes	No	
Cardiac / Heart Problems			If yes, what is the name of the medicine they take?
Do they take medicines?	Yes	No	
Diabetes (sugar in the blood)			If yes, what is the name of the medicine they take?
Do they take any medicines or injections?	Yes	No	
Epilepsy (fits or seizures)			If yes, what is the name of the medicine they take?
Do they take any medicines?	Yes	No	
Migraines			If yes, what is the name of the medicine they take?
Do they take medicines?	Yes	No	
Rheumatic Fever			If yes, what is the name of the medicine they take?
Do they take medicines or injections?	Yes	No	
Are there any **other medicines** that you haven't already mentioned?	Yes	No	If yes, what is the name of the medicine they take?
Is there anything else you think we should know about?			

E ALLERGIES

Allergic reaction:	Please circle				What happens to them?
Nuts	Severe	Moderate	Mild	No	
Bees	Severe	Moderate	Mild	No	
Medicines	Severe	Moderate	Mild	No	
Other	Severe	Moderate	Mild	No	
Have they ever been told that they require an **epipen**?	Yes		No		If yes, have you supplied the school with the appropriate medication that may be required? **YES / NO**

F VACCINATION DETAILS

Is the student vaccinated for measles?

YES NO

If YES, please provide date? __ / __ / __

Is the student vaccinated for tetanus?

YES NO

If YES, please provide date? __ / __ / __

Is the student vaccinated for Covid-19?

YES NO

If YES, please provide date? __ / __ / __

Evidence of vaccination ***must*** be shown by one of these methods:

1) Mycovid Record showing dates of vaccination given
2) A letter from a GP or Ministry of Health
3) Vaccine Passport

Students who do not provide evidence will be recorded as unvaccinated

G PERMISSION FOR GIVING MEDICATION AT SCHOOL

Sometimes it may be necessary for the nurse to consider giving students medication at school.

Medicine	Please circle	
Paracetamol (eg: Panadol)	Yes	No
Ibuprofen (eg: Nurofen)	Yes	No
Antihistamine	Yes	No

I give permission for the School Nurse to give:

_____

(student's name)

this medicine if they have examined them and believe that it would help.

Parent/Guardian Signature:

_____

Please print your name:

_____

NOTE

In case of a serious illness or accident students will be taken to a doctor for care. An ambulance may be called if necessary. Please ensure that the school has your most current contact details so that a parent/guardian may be called.

If you are unsure about any of the questions or would like to discuss any of the following please contact one of our Registered School Nurses 09 237 0195.