



**Manurewa High School**  
*'a tradition of excellence'*

# MEDICAL FORM

To assist our School Health Centre in providing the best possible care for your son/daughter 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.

**STUDENT'S NAME:** ..... **Year Level:** .....

**1 Family Doctor:** ..... Phone No: .....

**Dentist:** ..... Phone No: .....

**2 MEDICAL CONDITIONS**

My child has or has had the following disabilities, allergies or medical problems which may affect his/her performance or activities at school:

Medical Conditions	✓ Yes	Medication Required (see below), Other Details
Asthma (see Section 12)		
Diabetes		
Epilepsy		
Rheumatic Fever		
Hepatitis A or B / HIV		
Glandular Fever		
Migraines		
Sinus		
Hay Fever		
Heart Conditions		
Tuberculosis		
Nose Bleeds		
Recurring Abdominal Pain		
Back / Neck Problems		
Past Illness or Operations		
Nil		

**3 ALLERGIES**

Allergic Reaction To	✓ Yes	Specify Type
Bee Stings		
Medication		
Food		
Other		
Nil Known		

**4 MEDICATION**

Please send **labelled** medication to the School Nurse if it is required for regular use or for emergencies (ie Antihistamines for Bee Stings).

**5 Does your SON/DAUGHTER have on a regular basis:**

(a) Any medication not mentioned above?

(b) A course of treatment / counselling?

If **YES**, please detail

.....  
.....

**6 IMMUNISATION**

Has your son / daughter had Tetanus immunisation? *(please circle answer)*

**YES / NO**

If **YES**, list date of last Tetanus injection .....

**7 SENSORY LOSS YES / NO (please circle)**

If **YES**, specify type and degree below:

Problem Area	Right	Left	Bilateral	Amount (eg mild, 100%)
Visual (Eyesight)				
Hearing				
Device Used (eg Glasses, Hearing Aid)				

**8 OTHER RELEVANT CONDITIONS (eg Cardiac Murmur – limited PE, Cystic Fibrosis, etc)**

If **NO**, write N/A and go to Section 10.

If **YES**, please detail: .....

.....

**9 SPECIAL HOME CIRCUMSTANCES**

Are there any factors that may affect the student's behaviour or emotional stability?

If **NO**, write N/A and go to Section 11.

If **YES**, please detail: .....

.....

**10 ASTHMA SUFFERERS ONLY**

Does the student 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 GP/Practice Nurse.*

**11 PERMISSION FOR ADMINISTERING MEDICATION (eg Panadol, Antihistamine, Mylanta, topical creams, Cough Syrup)**

In some circumstances it is necessary for medication to be administered for such things as headaches, period cramps, hay fever, sinus, colds.

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

Parent/Guardian Signature .....

**In case of a serious accident or emergency, an ambulance will be called. A parent/guardian will also be called, so please ensure that the School has your most current contact details.**

The School realises that family circumstances and a student's health may change in the course of a year. It would be very much appreciated if the School is notified as soon as possible by either:

- (a) A phone call to the Health Centre
- (b) A phone call to the Main Office
- (c) A note to the Form Teacher

**Note** This information is for School purposes. The School reserves the right to pass on this information to other agencies it sees fit, to hold and store the information.