TE KAUWHATA COLLEGE

MEDICAL FORM FOR STUDENTS

Please read this form carefully and complete it as fully and as accurately as possible. If more details are required than this form provides space for, please make additional notes on page 4.
Please use BLOCK LETTERS when completing this form.

If your student requires any medication, either regularly or occasionally, we recommend that you leave a supply at the Student Centre. It will be held in your child's name and can be given to them when required.

Student's full name: _____

Name of Doctor:
- ❑ Te Kauwhata Health Centre
- ❑ DrS@42
- ❑ Huntly West Medical
- ❑ Hakanoa Health Centre
- ❑ Waahi Health Centre
- ❑ Huntly East Medical
- ❑ Other _____ Contact Ph: _____

Are we permitted to give your child Panadol/paracetamol if required? Yes / No

Present Health

1. Are there any medical conditions, injuries or other reasons that may limit your student's participation in PE activities? Yes / No
2. Is your child receiving medical attention at present? Yes / No
   If Yes, for what reason?
3. Does your child take regular medications? Yes / No
   If Yes, please give details:

Condition	Medication	Dosage	When Taken

4. Does your child take medications in particular circumstances? Yes / No
   If Yes, please give details:

Condition	Medication	Dosage	When Taken

5. Does your child have any medical condition not requiring medication? Yes / No
   If Yes, please give details:

6. Does your child have allergies (e.g. food items, medication, hay fever, etc.)? Yes / No
   If Yes, please give details including reactions and medication required.

Medical History

7. Are all your child's immunisations up to date? Yes / No
   If **No**, please give reasons why not.

8. Has your child had a tetanus injection? Yes / No

   If Yes, please provide the date:

9. Has your child ever had consultation with, or treatment from, the following specialists:

Specialist	When	Reason	Treatment	Follow Up
Orthopaedic				
Speech Therapist				
Physiotherapist				
Counsellor				

10. Does your child have any hearing problems? Yes / No

    If Yes, please give details:

11. Does your child have any vision problems? Yes / No

    If Yes, please give details:

12. Does your child have a physical disability? Yes / No

    If Yes, please give details:

    Would your child require special assistance at school? Yes / No

    If Yes, please give details:

13. Has your child had any of the following:

    Major accidents – if Yes, please give details:

    Operations – if Yes, please give details:

    Head injuries/concussion – if Yes, please give details:

14. Has your child shown, or been treated for, any of the following in the last 12 months:

    Aggression? Yes / No Depression? Yes / No

    Temper Tantrums? Yes / No Eating Disorders? Yes / No

    If Yes to any of the above, please give details:

15. Has your child ever suffered any of the following – if Yes, please give details:

Disease		Date	Treatment
Chicken Pox	Yes / No		
Measles	Yes / No		
Mumps	Yes / No		
Whooping Cough	Yes / No		
Glandular Fever	Yes / No		
Meningitis	Yes / No		
Bladder/kidney infection	Yes / No		
Anaemia	Yes / No		
Other (specify):	Yes/ No		

16. Does your child have any of the following – if Yes, please give details:

Disease		Date when first appeared/ diagnosed	Treatment
Epilepsy	Yes / No		
Diabetes	Yes / No		
Eczema	Yes / No		
Heart Condition	Yes / No		
Thyroid Disorder	Yes / No		
Asthma	Yes / No		
Haemophilia	Yes / No		
Recurring Headache/Migraine	Yes / No		
ME/Chronic Fatigue Syndrome	Yes / No		
Other (specify):	Yes/ No		

17. Has your child been **IMMUNISED** against the following ?:

NOTE We require a copy of current Immunisation records for filing **Attached: Yes**

Disease		
Covid 19	Yes / No	1st Dose Date: 2nd Dose Date:
Diphtheria	Yes / No	
Hepatitis B	Yes / No	
HIB	Yes / No	
Measles	Yes / No	
MeNZBTM	Yes / No	
Mumps	Yes / No	
Pertussis	Yes / No	
Polio	Yes / No	
Rubella	Yes / No	
Tetanus	Yes / No	
Tuberculosis	Yes / No	

Other Health-Related Information

Please record here any other health information you think could be relevant to your child's education or time at school?

I confirm that, to the best of my knowledge, the information I have given in this form is correct and accurate.

I understand that, IN THE CASE OF AN ACCIDENT, EMERGENCY OR SERIOUS ILLNESS/INJURY, I will be contacted. If, however, the school cannot contact me, or any of the emergency contacts I provide, I agree to the school administering first aid assistance and/or emergency medical treatment (e.g. calling an ambulance or taking your child to a doctor) if required and I agree to meet any costs incurred.

I will inform the school if there are any changes relating to the health of my child.

Parent/Caregiver's Name: _____

Relationship to Student: _____

Signature: _____ Date: _____

Office use only:

Details checked with parent/ caregiver by enrolling officer: *(Inits)*	Date:	Details entered onto SMS: *(Inits)*	Date:

ADDITIONAL HEALTH INFORMATION