ALBANY JUNIOR HIGH SCHOOL

EMPOWER TO EXCEL

HEALTH INFORMATION Confidential - File in Health Centre

Please complete ALL relevant sections

Student's Name _____ DOB _____

Parent/Caregiver Name _____

Home Ph _____ Work Ph _____ Mobile Ph _____

ASTHMA MEDICATION

	Name	Dose	How often
Preventer	_____	_____	_____
Reliever	_____	_____	_____

Best Peak Flow _____ Does the student have an asthma plan? Yes ☐ No ☐

If, Yes please give the school nurse a copy of the action plan. If using preventers, The NZ Asthma Society recommends this plan be updated 6 - 12 monthly – See GP/Practice Nurse.

ALLERGIES

All students that require an Epipen must provide the school nurse with a current Allergy Plan signed by a medical officer.
If your child may require antihistamine please provide medication to School Nurse, clearly labelled with name and dose.

Allergen	Reaction	Treatment
_____	_____	_____

Please list all plants, food, animals, sticking plaster or medication that your child is allergic to:

_____

DIABETES

On medication Yes ☐ No ☐ If Yes indicate ☐ Insulin ☐ Tablets

Please give details of other relevant conditions enclosing copies of any relevant medical information, Doctor's/Specialist's letters (Eg: Heart murmur, visual impairment, sensory loss (hearing), epilepsy, ADHD, migraine, travel sickness, dizzy spells, special diet, chronic nose bleeds, colour blindness)

_____

_____

_____

Is there any information staff should know to ensure the physical and emotional safety of you/your child? Yes ☐ No ☐
(Eg: cultural practices, disability, anxiety about heights/darkness/small spaces, pregnancy, behaviour or emotional problems, sleepwalking)

_____

Is your child enrolled in the School Dental Programme? Yes ☐ No ☐
Please provide name and address of the student's GP and Dental Practice

GP Name _____ Dental Practice Name _____

Address _____ Address _____

Telephone No. _____ Telephone No. _____

- I give my permission to disclose this information to appropriate staff Yes ☐ No ☐
- In event of emergency I consent to any incurred costs (ie ambulance) Yes ☐ No ☐
- I consent to my son/daughter receiving Panadol for minor ailments

Signed: _____ Date: _____
Parent/Caregiver/Guardian

See Over

ALBANY JUNIOR HIGH SCHOOL

EMPOWER TO EXCEL

IMMUNISATIONS

My child has been fully immunised to 5 years **Yes / No** (Please Circle)

My child has been partially immunised **Yes / No** (Please Circle)

If your child has been partially immunised please indicate below which immunisations have been received.
Please ✓ immunisations received

☐	6 weeks	Diptheria/Tetanus/Whooping cough/Polio/Hepatitis B/Haemophilus influenzae type b = 1 injection (Infanrix - hexa), Pneumococcal = 1 injection (Prevenar)
☐	3 months	Diptheria/Tetanus/Whooping cough/Polio/Hepatitis B/Haemophilus influenzae type b = 1 injection (Infanrix - hexa), Pneumococcal = 1 Injection (Prevanar)
☐	5 months	Diptheria/Tetanus/Whooping cough/Polio/Hepatitis B/Haemophilus influenzae type b = 1 injection (Infanrix - hexa), Pneumococcal = 1 Injection (Prevanar)
☐	15 months	Haemophilus Influenzae type b = 1 injection (Hiberix) Measles/Mumps/Rubella = 1 injection (M-M-R II), Pneumococcal = 1 injection (Prevenar)
☐	4 years	Diphtheria/Tetanus/Whooping cough/Polio = 1 injection (Infanrix - IPV), Measles/Mumps/Rubella = 1 injection (M-M-R II)
☐	11 years	Diphtheria/Tetanus/Whooping cough = 1 injection (Boostrix)
☐	12 years	Human papillomavirus = 3 doses given over 6 months (Gardasil) - Girls only

Please note: Boostrix in Year 7 and HPV in Year 8 are given at school through the Ministry of Health with parental consent.

ADMINISTRATION OF MEDICINE

Specialist Name _____ Contact No. _____

My child requires the following prescription medication at school:

Drug Name _____

Dose _____ Due _____

Commencing _____ Finishing _____

My child is taking this medication because he/she has

_____

_____

Any further details

_____

_____

- I accept full responsibility for maintaining supplies, having my child's name, name of drug and correct dose on the container and that supplies will not have passed the expiry date.
- I give permission for the school nurse or other designated staff member to administer this medication according to my child's needs.
- I accept that the school will take due care with the administration of this medication, but I release the school and the school staff from any responsibility associated with it.
- I will inform the school in writing if there is any change in the above medication information.
- The school will accept responsibility for keeping this information safe.

Full Name: _____ Signature: _____
Parent/Caregiver/Guardian Parent/Caregiver/Guardian

Date: _____ Entered onto KAMAR _____