ASDAH Health History Form

Please read carefully, sign and return to school:

This form will used for EOTC purposes, excursions and any off campus events.

Please answer the following questions about the student you are enrolling so that we can take care of them if they get sick or hurt. The form will be kept in the Nurse's office and will only share this information with others who need to know.

Please advise the Health Centre of any changes in health information.

Further health information will be updated on permission slips.

Contact:

Joanne Longstaff

School Nurse

Ph. 275 9640 ext. 703 nurse@asdah.school.nz

Jessie Fuamatu

Deputy Principal

Ph. 275 9640 ext. 702 Jessie@asdah.school.nz

Student's Name..... Date of Birth.....

Year level..... Hospital Number (NHI).....

Name of person filling out this form:

Name..... What is your relationship to student? .....

Which Doctor/clinic does the student go to? ..... Phone.....

Which Dentist does the student go to? ..... Phone.....

Who do we contact in case of an emergency?

1. _____ Phone _____

2. _____ Phone _____

Has your child had the following? (Please circle answer)

Rubella/German Measles	Yes No	English Measles	Yes No
Chicken Pox	Yes No	Mumps	Yes No

Has your child had the following immunisations? (Please circle answer)

If able please attach copy of immunisations.

MMR (Measles/Mumps/Rubella)	Yes No	Tuberculosis (BCG)	Yes No
Hepatitis	Yes No	Rubella	Yes No
Tetanus	Yes No		

MEDICAL CONDITIONS		
Have they ever been a patient in hospital overnight?	Yes No	If **Yes** why?
Asthma (trouble breathing) Do they have an inhaler? Do they have an "Asthma Action Plan?"	 Yes No Yes No	If **Yes** What is the name of the medicine they take?
Diabetes (sugar in the blood) Do they take medicine or injections?	 Yes No	If **Yes** What is the name of the medicine they take?
Epilepsy (fits or seizures)	Yes No	If **Yes** What is the name of the medicine they take?
Rheumatic Fever (heart problems) Do they take medicine or injections?	Yes No	If **Yes** What is the name of the medicine they take?
Eyesight problems	Yes No	
Hearing problems	Yes No	
Recurring abdominal pain	Yes No	If Yes What is the name of the medicine they take?
Recurring nosebleeds	Yes No	
Headaches / Migraines	Yes No	If Yes What is the name of the medicine they take?
Back / Neck problems	Yes No	If Yes What is the name of the medicine they take?
Skin problems	Yes No	If Yes What is the name of the medicine they take?
Is the student seeing a counsellor?	Yes No	If Yes, why?
Are there any other medications that you haven't already mentioned?	Yes No	
Is there anything else you think we should know?	Yes No	

Is there anything else you would like to add?

Is there anything that makes the student unwell if they eat it, breathe it or touch it?

ALLERGIC REACTION TO	WHAT HAPPENS TO THEM?

Health Checks

Year 9 students will be given a routine health assessment – this will include measuring height, weight, hearing, vision and blood pressure, plus a discussion on nutrition, exercise, physical, emotional, mental health and hygiene. (Parents will be notifies if necessary and are welcome to contact the nurse with any queries.)

Health Centre Visits

Unwell students that are assessed in the Health Centre may require medication.

If required I give consent for my child to have:

Paracetamol, Panadol, throat lozenges, Ibuprofen, Mylanta or antihistamines Yes No

Throat swabbing if required Yes No

Consent to see the School Doctor Yes No

In case of accident or emergency

In case of accident or emergency and the school cannot contact you, or if the accident is serious, the school nurse or teacher in charge may arrange for your child to be taken to the doctor or accident and emergency clinic.

I give permission for the school to make these necessary arrangements for the treatment of my child in an emergency and agree to meet any costs incurred.

I understand the range of services being provided by the school health centre and consent to my child accessing these services.

Parent/Guardian signature _____ Date _____