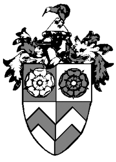

Rosehill College Student Health Record

The information collected on this form is to assist in the case of accident or emergency, or to assess any special needs the student may have – please complete it in full. This information will be stored securely and access is limited to the school Health Professional or, on request, the student him/herself.
If considered necessary, for safety reasons, a limited version may be distributed to staff members immediately responsible for the student e.g. Physical Education or Food Technology staff.

If you consider any of the information to be confidential please enclose this form in an envelope marked "Confidential Medical Information" or you can provide additional information by emailing nurses@rosehillcollege.school.nz or you can phone the Nurse on (09) 295 0661 ext 491 or 492

PLEASE COMPLETE BOTH SIDES FULLY AND SIGN

STUDENT DETAILS YEAR LEVEL :

Family Name: ……………………………………………. First Name: ……………………………………………. Preferred Name: ………………………………………………

Date of Birth: ………………………………………. Country of Origin: ……………………………………………………………………………

Home address: …………………………………………………………………………………………… Home phone: ………………………………….

PARENT / CAREGIVER DETAILS:

Mother's Name: .... Daytime Ph.: .... Mobile: ....

Father's Name: .... Daytime Ph:...................................... Mobile: ....

MEDICAL CONTACT DETAILS

Doctor's Name:.. Address: .... Phone: ....

Dentist's Name: .... Address:....................................... Phone: ....

HAS THE STUDENT EVER SUFFERED FROM:

Condition	Yes	No	When	Details, Treatment & Medications
Allergy	☐	☐	…………………	…………………………………………………………………………………………
Anxiety/depression/ Eating disorder/other mental health issues	☐	☐	…………………	…………………………………………………………………………………………
Asthma	☐	☐	…………………	…………………………………………………………………………………………
Diabetes	☐	☐	…………………	…………………………………………………………………………………………
Epilepsy	☐	☐	…………………	…………………………………………………………………………………………

HAS THE STUDENT EVER SUFFERED FROM:

Condition	Yes	No	When	Details, Treatment & Medications
Learning difficulty ADHD, autism spectrum, dyslexia etc	☐	☐	....	....
Heart Condition Including rheumatic fever	☐	☐	....	....
Other (eg eczema)	☐	☐	....	....

DOES HE/SHE HAVE ANY DIFFICULTY WITH HIS/HER:

	Yes	No		Yes	No
Sight	☐	☐	Hearing	☐	☐
Does he/she wear glasses?	☐	☐	Are hearing aids worn?	☐	☐
Or contacts?	☐	☐			

Details: ....

IMUNISATION DETAILS

	Yes	No
Has your child been fully immunised?	☐	☐

If partially immunised please provide details ____

____

PRESCRIPTION MEDICATION:

Bringing prescribed medicine to school is discouraged. If your son/daughter needs to take medication during school hours please inform the school nurse (in writing, by email or phone) and make arrangements for medication to be kept in the Health Centre.

CONSENT FOR MEDICATION:

Your consent is required for the administration of Non Prescription medication by the Rosehill College Registered Nurse. These include those to relieve cough and cold symptoms, pain, elevated temperature, inflammation, allergies and sports injuries.

Most commonly used medications:

Category A: ***Paracetamol/Nurofen/Ibuprofen*** **for pain,** ***Strepsils*** **for sore throats and** ***Propolis lozenges*** **for coughs,** ***Mylanta liquid/tablets*** **for indigestion/acid reflux,** ***Refresh*** **eye drops.**

Please delete any of the above medications is they are not suitable for your child.

I consent to the above medications. Yes ☐ No ☐

Category B: ***Antihistamines eg Loratabs (These medications would only be administered if the student usually takes this medication or in the event of an allergic reaction or hayfever symptoms.***

Please delete any of the above medications is they are not suitable for your child.

I consent to the above medications. Yes ☐ No ☐

CONSENT TO SEE SCHOOL DOCTOR (IF CHILD IS UNDER 16 YEARS)

We have a doctor onsite at school providing a GP service for a few hours per week.

I consent to my child seeing the School Doctor. Yes ☐ No ☐

IN CASE OF ACCIDENT OR EMERGENCY:

If an accident or emergency occurs and the school is unable to contact you the school nurse and/or doctor may decide to take your son/daughter to an A & E or Medical Centre doctor or phone for an ambulance.

I / We give permission for the school nurse and/or doctor to treat or refer my son/daughter and agree to meet any costs incurred.

Signature/s: ………………………………………………………………………………………… Date: ....