MOUNT ALBERT GRAMMAR SCHOOL
STUDENT HEALTH RECORD

Alberton Avenue, Mount Albert, Auckland 1025, New Zealand.
Telephone: +64 9 846 2044 Fax: +64 9 846 2042 Website: mags.school.nz Email: enrol@mags.school.nz

STUDENT SURNAME:	**FIRST NAME:**	**DATE OF BIRTH:**	**Gender:**

Primary Caregiver Name / relationship to student:	Daytime Phone:
Primary Caregiver Name / relationship to student:	Daytime Phone:

EMERGENCY CONTACT during the day if parents/caregivers cannot be contacted:

Name / relationship to student:	Daytime Phone/Mobile:
Family Doctor/ GP	Contact details:

Medical Conditions- select as appropriate.		**Please provide as much detail as possible for all conditions selected (ie date of diagnosis, medication required, treatment plans etc), attach extra sheet of paper if required.**
Asthma Mild / Moderate / Severe- please circle	Yes ☐ No ☐	*On medication? Please specify:*
Diabetes	Yes ☐ No ☐	*On insulin injections/ pump? Please provide details:*
Allergy / Allergies Mild / Moderate / Severe Does the student carry their own EPIPEN	Yes ☐ No ☐ Yes ☐ No ☐	*If Anaphylaxis, please supply up to date action plan:*
ADHD / ADD	Yes ☐ No ☐	On medication? Please provide details:
Epilepsy	Yes ☐ No ☐	*Date of last seizure:*
Past Head Injury With ongoing concerns	Yes ☐ No ☐	*Please specify any ongoing concerns and current management plans:*
Rheumatic Fever	Yes ☐ No ☐	
Any other medical condition *(please give details)*	Yes ☐ No ☐	*Please specify:*

Vaccinations- please provide copy of vaccination history. Tetanus up to date Yes ☐ No ☐ **Date of most recent tetanus vaccination:**
COVID 19 vaccination : Yes ☐ No ☐ **Please provide details if applicable:**

IF YOU HAVE ANSWERED YES TO ANY MEDICAL CONDITION – PLEASE provide as much detail as possible, this ensures we are able to care for your student safely whilst they are at school. If we require any further information the school nurse will be in contact.

PERMISSION- Please ensure form is signed and dated!!

1. **I give permission for my child to receive appropriate treatment when necessary by the School Nurse, and for the School Nurse to administer non-prescription medicines e.g. Paracetamol, Mylanta, antihistamine, throat lozenges on the occasion deemed necessary.**
2. **If the school is unable to contact anyone on the above contact numbers, or if the accident is serious, I give permission for the School Nurse or delegate to organise for my child to be taken to *Accident and Emergency,* the doctor or physiotherapist.**
3. **I give permission for the school to make arrangements as are deemed necessary for the treatment for my child in an emergency and agree to meet any costs incurred.**

I give permission for the School's Registered Nurse to act on my behalf in the situations outlined above Yes ☐ No ☐

Parent/Guardian Signature _____ **Date** _____