



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: enrolments@mags.school.nz

STUDENT SURNAME:	FIRST NAME:	DATE OF BIRTH:	MALE <input type="checkbox"/>
			FEMALE <input type="checkbox"/>
Mother / Caregiver Name:	Home Phone:	Daytime Phone/Mobile:	
Father/ Caregiver Name:	Home Phone:	Daytime Phone/Mobile:	
EMERGENCY CONTACT during the day if parents/caregivers cannot be contacted:			
Name:	Relationship to Student:	Daytime Phone/Mobile:	

Has this student ever suffered from?	Tick one (v)	Date medication started	Medication and Frequency (if any)	Please indicate as appropriate: Mild / Moderate / Severe
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Allergy (please specify e.g. penicillin, nuts, bee stings)	Yes <input type="checkbox"/> No <input type="checkbox"/>			If Anaphylaxis, please supply action plan
ADHD / ADD	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>			Date of last seizure:
Past Head Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>			Any ongoing issues?
Hepatitis B	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Any other medical condition (please give details)	Yes <input type="checkbox"/> No <input type="checkbox"/>			

Family Doctor Name:
Phone:

Has he/she had the following vaccinations:	Date of vaccination:	
Hepatitis B	Yes <input type="checkbox"/> No <input type="checkbox"/>	
HiB	Yes <input type="checkbox"/> No <input type="checkbox"/>	
MMR (Measles, Mumps, Rubella)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Polio	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Tetanus	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diphtheria	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Whooping cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Gardasil	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other? (please give details)	Yes <input type="checkbox"/> No <input type="checkbox"/>	

**IF YOU HAVE ANSWERED YES TO ANY MEDICAL PROBLEM –
 PLEASE CONTACT THE SCHOOL NURSE (EXT 8108) TO DISCUSS APPROPRIATE CARE AND TO FORMULATE AN ACTION PLAN.**

PERMISSION GRANTED IN CASE OF AN ACCIDENT OR EMERGENCY

- 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.
- 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.
- 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.

Parent/Guardian Signature _____

Date _____