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:**	**MALE** ☐ **FEMALE** ☐
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 (√)	**Date medication started**	**Medication and Frequency** (if any)	**Please indicate as appropriate: Mild / Moderate / Severe**
Asthma	Yes ☐ No ☐			
Diabetes	Yes ☐ No ☐			
Allergy *(please specify e.g. penicillin, nuts, bee stings)*	Yes ☐ No ☐			If Anaphylaxis, please supply action plan
ADHD / ADD	Yes ☐ No ☐			
Epilepsy	Yes ☐ No ☐			Date of last seizure:
Past Head Injury	Yes ☐ No ☐			Any ongoing issues?
Hepatitis B	Yes ☐ No ☐			
Rheumatic Fever	Yes ☐ No ☐			
Any other medical condition *(please give details)*	Yes ☐ No ☐			

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.

Family Doctor Name:
Phone:

Has he/she had the following vaccinations:		**Date of vaccination:**
Hepatitis B	Yes ☐ No ☐	
HiB	Yes ☐ No ☐	
MMR (Measles, Mumps, Rubella)	Yes ☐ No ☐	
Polio	Yes ☐ No ☐	
Tetanus	Yes ☐ No ☐	
Diptheria	Yes ☐ No ☐	
Whooping cough	Yes ☐ No ☐	
Gardasil	Yes ☐ No ☐	
Other? *(please give details)*	Yes ☐ No ☐	

PERMISSION GRANTED IN CASE OF AN ACCIDENT OR EMERGENCY

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.

Parent/Guardian Signature _____ Date _____