



Student Health Record

To help maintain records for the Health Department and to help us care for your son in an illness/emergency situation, could you please answer the following questions.

Student's Surname: _____ **First Names:** _____

Date of Birth: _____

Family Doctor: _____ Phone No.: _____

1. Does your son suffer from a condition/illness that may need treatment or drugs? Yes / No
2. Is your son fully vaccinated against:
 - Hepatitis B Yes / No
 - MMR Yes / No
 - Polio Yes / No
 - Meningococcal B Yes / No
 - Diphtheria Yes / No
 - Whooping Cough (Pertussis) Yes / No
 - Tetanus Yes / NoDate of last booster: _____ (month) _____ (year)
3. Has your son ever suffered from the following: *(please indicate if mild, moderate or severe)*
 - Asthma Yes / No
 - Diabetes Yes / No
 - Epilepsy Yes / No
 - Rheumatic Fever Yes / No
 - Glandular Fever Yes / No
 - Tuberculosis Yes / No
 - Hepatitis Yes / No
 - Allergies Yes / No
 - Heart Condition Yes / No
 - Migraines Yes / No

Any disabilities including learning disabilities?

4. Do you give permission for your son to be treated in the Health Centre for minor ailments and be given medication such as Panadol (paracetamol) and/or be given first aid for an injury he may sustain?
Yes / No

In case of an accident or emergency if the School cannot contact you, or if the illness is serious, the School Nurse or a senior member of staff may need to take your son to an Accident and Emergency Clinic or to a hospital.

I give permission for the School to make such arrangements as are necessary for the treatment of my son in an emergency and agree to meet any costs incurred.

Parent / Guardian Signature: _____ Date: _____

Telephone the Health Centre on 623 5637 between 10am-3pm if you wish to discuss anything with the School Nurse