Mokoia Intermediate School
Health Profile

This profile is designed to assist with the care of students at school and on EOTC events.

Child's Name: _____

1. Please tick if your child has any of the following:

❑ Migraine ❑ Diabetes ❑ Chronic nose bleeds ❑ Colour blindness ❑ ADHD	❑ Epilepsy ❑ Travel sickness ❑ Heart condition ❑ Allergies ❑ Asthma	❑ Fits of any type ❑ Dizzy spells ❑ Other (Please specify) _____

For overnight events:

❑ Sleepwalking	❑ Bedwetting	❑ Anxiety

Doctor's Name_____ **Phone No.**_____

2. Does your child take regular medication? YES / NO

If **YES**, please state: Health condition/s: _____

Name of medication/s: _____

Dosage and time/s to be taken: _____

Other Treatment: _____

Is a health plan required? YES / NO *(Please provide)*

Has your child had any major injuries or illness that may limit full participation in any activities? YES / NO

If YES, please state the injury/illness: _____

Medic Alert Number: _____

3. Is your child allergic to any of the following?

	YES	**NO**	**Please specify**
Prescription medication			

Food			
Insect bites/stings			
Other allergies			
What treatment is required?			

4. When was your child's last tetanus injection? _____

5. Outline any dietary requirements: _____

_____

6. Can pain medication be given to your child if necessary? (Panadol tablet) YES / NO

7. Is there any information we should know to ensure the physical and emotional safety of your child? (For example cultural practices; disability; anxiety about heights/darkness/small spaces; behaviour or emotional problems).

If YES, please state or attach the information: _____

_____

_____

_____

_____

_____

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Please tick

- ❑ I agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration.
- ❑ I will inform the school as soon as possible of any changes in the medical or other circumstances.
- ❑ I agree to my child receiving any emergency medical treatment. *(Please contact the school office with details if this box is not ticked)*
- ❑ Any medical costs not covered by ACC will be paid by me.

Parents signature: _____ Date: _____