



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:

<input type="checkbox"/> Migraine <input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic nose bleeds <input type="checkbox"/> Colour blindness <input type="checkbox"/> ADHD	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Travel sickness <input type="checkbox"/> Heart condition <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma	<input type="checkbox"/> Fits of any type <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Other (Please specify) _____
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For overnight events:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other (Please share concerns with your child's teacher)
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Doctor's Name _____ Phone No. _____

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

The school will only administer prescription medication to students whose parents have made a formal request. Parents/caregivers need to complete a **Medicine Authority Form**

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: _____

Details:

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. Is your child fully immunised against Measles, Mumps and Rubella (MMR)? YES/NO
Please provide confirmation from your G.P. if possible

6. Outline any dietary requirements:

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

8. 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; Family custody requirements; behaviour or emotional problems)

If YES, please state or attach the information: _____

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. Any medical costs not covered by ACC will be paid by me. In the case of a medical emergency where no one can be contacted to obtain permission we agree to reimburse expenses incurred to the school.

Parents signature: _____ Date: _____