



MARIST COLLEGE

Catholic School for Girls, Years 7 to 13

Section C: Student Health Record

Student Information

First name:

Mother/Guardian/
Caregiver 1 Name:

Father/Guardian/
Caregiver 1 Name:

Date of birth:

Last name:

Home Phone:

Daytime/Mobile Ph:

Home Phone:

Daytime/Mobile Ph:

Emergency contact (during the day if parents/caregivers cannot be contacted):

Name:

Daytime/Mobile Ph:

Relationship to Student:

General medication approval:

Panadol/Paracetamol: ☐ Yes ☐ No

Ibuprofen ☐ Yes ☐ No

Medical History

Has this student ever suffered from any of the following medical conditions?

	Please tick one	Date started medication	Medication/Treatment and frequency (if any)	Please indicate level: Mild/Moderate/Severe
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergy (please specify eg. Penicillin, nuts, bee stings)	<input type="checkbox"/> Yes <input type="checkbox"/> No			If Anaphylaxis, please supply action plan
ADHD / ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Epilepsy / Seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No			Date of last seizure:
Past Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No			Any ongoing issues?
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Any other medical condition? (Please give details)	<input type="checkbox"/> Yes <input type="checkbox"/> No			

If you have answered YES to any medical problem – please contact the School Nurse (extn 705) or email nurse@maristcollege.school.nz to discuss appropriate care and to formulate an action plan.

Vaccinations

Has a copy of the vaccination certificate or vaccination report from the doctor been supplied? ☐ Yes ☐ No

Family Doctor Name:

Phone:

Has this student has the following vaccinations?

Vaccination	Please tick one	Date of vaccination:	Vaccination	Please tick one	Date of vaccination:
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HiB	<input type="checkbox"/> Yes <input type="checkbox"/> No		Diphtheria	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MMR (Measles, Mumps, Rubella)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No		Gardasil	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other? (Please give details)	<input type="checkbox"/> Yes <input type="checkbox"/> No				

If any of these details change, or the student has new vaccinations added please contact the School Nurse (extn 705) or email nurse@maristcollege.school.nz to amend these details.

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 / First Aid trained staff and for the School Nurse / First Aid trained staff 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: