



TAKAPUNA GRAMMAR SCHOOL

210 Lake Rd PO Box 33 1096 Takapuna Auckland 0740 New Zealand
 T: 09 489 4167 F: 09 486 7118 E: office@takapuna.school.nz
 www.takapuna.school.nz

Student Health Record (CONFIDENTIAL)

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

Student's Surname: _____ First Names: _____

Family Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone: _____

Dentist Name: _____ Dentist Phone: _____

Does your son/daughter have or ever suffer from: (specify treatment and medication if required)

Asthma Yes No

Diabetes Yes No

Epilepsy Yes No

Rheumatic Fever Yes No

Hepatitis A, B or C Yes No

Glandular Fever Yes No

Tuberculosis Yes No

HIV or AIDS Yes No

ADD, ADHD Yes No

Heart Condition Yes No

Does your son/daughter have or ever suffer from: (specify what type of reaction and what medication is required)

Allergic reaction to stings Yes No

Allergic reaction to food Yes No

Allergic reaction to medication Yes No

Allergic reaction to other Yes No

Does he/she suffer from any other physical or mental condition or disability? Yes No

Please state condition or disability: _____

Does he/she take any other medication on a regular basis? Yes No

Please list medication: _____



Has your son/daughter had the following vaccinations:

Meningococcal B Yes No

Measles/Mumps/Rubella (MMR) Yes No

Hepatitis B Yes No

Tuberculosis (BCG) Yes No

Polio & Triple Vaccine Yes No

ACCIDENT OR EMERGENCY SITUATIONS

If the school is unable to contact you or if the accident or emergency is serious, the Nurse may decide to take your child to the Medical Centre affiliated with the school or to the North Shore Hospital A & E Department.

I give my permission for the Nurse to make such arrangements as believed necessary and I will meet the costs incurred. I give my permission for 'over the counter' medication to be given to my child for the relief of minor ailments and that I have fully disclosed all information relating to the above and accept responsibility for any outcomes from non-disclosures.

Parent's Signature: _____

Date: _____

(THE STUDENT HEALTH NURSE IS AVAILABLE 8.30AM-3.15PM MONDAY TO FRIDAY)

PERSONALISED ACTION PLAN FOR STUDENTS WITH ASTHMA AT SCHOOL

Has _____ been in hospital for asthma? Yes No How often? _____

Date of last visit: _____ Name of Hospital: _____

Other information: (e.g. specialist's instructions) _____

Inhalers to be used at school and how often: _____

Inhaler Colour: _____ Inhaler is kept: (where?) _____

Is Inhaler to be used before exercise? Yes No

Is Inhaler to be used during exercise? Yes No

Is Inhaler to be used after exercise? Yes No

Best Peak Flow: _____

State student's symptoms during an asthma attack: _____

At start of asthma attack, please give: _____

If this does not work after _____ minutes give: _____

If condition not relieved by this, Parent/Caregiver will be notified immediately and ambulance will be called if necessary.

Parent/Caregiver Name: _____

Signed: _____

Date: _____