



## WHANGAPARĀOA COLLEGE

### Learner Health Record

This information is requested to assist us to care for your learner in case of illness or emergency. Please complete as fully as possible. If you have any queries, please contact our school nurse, Alexis Purvis – Tel. 09 424 9177 ext 235.

#### Learner Details

Learner's Full Name:	Date of Birth:
Doctor's Name / Practice:	Dentist's Name / Practice:

#### Immunisation

Fully immunised:      Yes / No      (Please Circle)

\*\* Please include Proof of Immunisation records (eg: Plunket book or print out from your GP) \*\*

#### Medical Information

Condition	Tick if Yes	Details (Inc. Medications and/or Treatment)
ADHA / ADD / ASD (if Yes, please provide documentation)		
Anxiety		
Asthma		
Diabetes		
Epilepsy / Seizures		
Heart Condition		
Headache / Migraine		
Hearing Loss		
Mental Health Condition		
Previous Head Injury		
Skin Condition		
Vision Loss		
Other		

## Allergies

Allergy	Tick if Yes	Details (incl. Medications and /or Treatment)
Bee / Wasp Sting		
Food		
Hayfever		
Medication		
Other		

## Consent to Medication

Medication	Initial to Give Consent
Paracetamol – for pain relief and fever	
Ibuprofen – for pain relief and fever	
Anti-histamine – for hayfever and other allergic reactions	

## Dental and Immunisation Programmes

Your learner has access to free dental and immunisation programmes. The school will provide basic information, such as a child's name, DOB, contact details and ethnicity, to the school dental service and WDH B Public Health Service.

Consent forms will be sent home during the year on which you can choose to consent, or not consent, to these services.

If you consent to this, the dental and immunisation teams will communicate with you directly prior to any treatment.

## Medication

Any controlled medication (such as Ritalin or Rubifen) needs to be kept in a locked cupboard at school and administered by the registered nurse. Please email [nurse@wgpcollege.school.nz](mailto:nurse@wgpcollege.school.nz) to arrange.

I give permission for the above medication / information to be given as appropriate:

Parent / Caregiver Name: \_\_\_\_\_

Parent / Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_