ENROLMENT OFFICER USE ONLY	HEALTH CENTRE USE ONLY
Student ID _____	Date Entered _____
Date Starting _____	Entered by _____

KingsWay School

MEDICAL INFORMATION

Student's Name: (First)……..(Surname)……
Date of Birth:……
Student's Class Level……

When completed please save this document to your system, then email it as an attachment to either enrolments enrolment@kingsway.school.nz or if requested by a school nurse, healthcentre@kingsway.school.nz

*******PLEASE ADVISE THE SCHOOL IMMEDIATELY OF ANY CHANGES TO CONTACT DETAILS OR MEDICAL CONDITIONS*******

1. Does your son/daughter suffer from any of the following *(Please tick)*

Anaphylactic shock	Yes		No	
Allergies	Yes		No	
Blackouts	Yes		No	
Migraine	Yes		No	
Heart Condition	Yes		No	
Travel Sickness	Yes		No	
Dizzy Spells	Yes		No	
Fits of any type	Yes		No	
Diabetes	Yes		No	
Asthma (explain severity)	Yes		No	
Back problems	Yes		No	
Arthritis	Yes		No	
ADD or ADHD	Yes		No	

Other Conditions (specify):

If you indicated YES for any of the above conditions, please supply any relevant details that may be necessary for emergency care, and/or ongoing care during school hours and/or school trips. Indicate any medication that is needed at school (these must be provided by you and will be kept in the school health centre).

Condition:
Details:
Condition:
Details:
Condition:
Details:
Condition:
Details:

2. Does your son/daughter have (*please tick*)

Eyesight Problems	Yes		No	
Hearing Difficulties	Yes		No	

Specify:

3. Does your son/daughter have any allergies *(please tick)*

Food	Yes		No		Bee / Wasp Stings	Yes		No	
Drugs	Yes		No		Penicillin	Yes		No	
Aspirin	Yes		No		Other	Yes		No	

Specify:

4. If not already done so, please provide a copy of your child's most recent **Immunisation Certificate**.

5. Do you give consent for staff to administer each of the below medications.

Paracetamol (age and/or weight appropriate dose) **Note: a prescription is required for liquid paracetamol**	Yes		No	
Ibuprofen (age and/or weight appropriate dose) **Note: for middle and senior students only**	Yes		No	
Topical creams (for treating bites, burns, bruises, aches, and pains)	Yes		No	

Any other medication/s your child requires during school hours, must be given to the school nurse in its original container, with a pharmacy label attached. You will be asked to complete a consent to administer medicine/s at school form. Medication must be kept in the health centre. Students (Years 1-6) must not carry medication/s in their school bag or keep them in their desk

Children who become unwell during school hours are sent to the Health Centre. If the child does not improve within an hour, parents are contacted to collect the child. Please supply the name of a friend or relative who can collect your son/daughter in the event of staff being unable to contact parents or caregivers.

Mother phone	**(home)**	**(work)**	**(Mob)**
Father phone	**(home)**	**(work)**	**(Mob)**

Name of alternate caregiver:
Relationship:
Address:
Phone Number: (home) (Mob)

Please ensure that the person you have named above is aware they have been listed as a contact. ***IN THE EVENT OF AN EMERGENCY AND WE ARE UNABLE TO CONTACK ANYONE, A STAFF MEMBER WILL TAKE YOUR CHILD TO THE NEAREST MEDICAL CENTRE AND ACT AS 'LOCO PARENTIS', OR AN AMBULANCE WILL BE CALLED.***

Please supply any additional information that you consider important for staff to know in the treatment and care of your child at KingsWay School.

Name of Doctor:……Phone……..

Name of Dentist / Dental Nurse…….. Phone……..

Signed:……*Parent/Caregiver*

Date:……

THE INFORMATION SUPPLIED ON THIS FORM IS SUBJECT TO THE PROVISIONS OF THE PRIVACY ACT 1993. INFORMATION IS CONFIDENTIAL TO THE STAFF OF KINGSWAY SCHOOL AND USED FOR THE PURPOSE OF CARING FOR STUDENTS AT SCHOOL AND WHILE ON SCHOOL TRIPS