Whanganui City College

CONFIDENTIAL MEDICAL REPORT

Please complete and sign the declaration on the back page and return with your enrolment form. Please disclose fully all information pertaining to your child's physical, mental, psychological and emotional wellbeing to ensure that Whanganui City College staff can adequately meet the pastoral needs of your child. Failure to disclose information could be viewed as a breech of the enrolment agreement. This form will be held on file in the International Office.

For Office use only

STUDENT

Surname: _____

Given name: _____

Date of Birth: _____

House: _____

Starting date: _____

PARENTS/GUARDIANS

Surname: _____ Given Name: _____

Address: _____

Phone Home: _____ Mobile: _____ Work: _____

Email address: _____

Surname: _____ Given Name: _____

Address: _____

Phone Home: _____ Mobile: _____ Work: _____

Email address: _____

Name of family doctor: _____ Phone: _____

International Student Contact Details in New Zealand:

Surname: _____ Given Name: _____

Address: _____

Phone Home: _____ Mobile: _____ Work: _____

Email address: _____

Does your child wear:- Contact Lenses Glasses Hearing Aid *Please Circle if Yes*

What is your childs blood type _____

Is your child an **asthmatic?** ` ☐ NO ☐ YES

Has your child ever been hospitalised due to asthma? ☐ NO ☐ YES

➔ Medication: _____

➔ Dose & frequency: _____

➔ Date of most recent hospitalisation: _____

➔ Details/treatment received: _____

_____

_____

Does your child have any **allergies?** (Including *food allergies)* ☐ NO ☐ YES

➔ What triggers the allergy? _____

➔ Medication/Treatment: _____

_____

Has your child ever suffered an **anaphylactic shock**? ☐ NO ☐ YES

➔ Details: _____

_____

Does your child have **diabetes?** ` ☐ NO ☐ YES

If yes a separate Diabetic Care Plan will also need to be completed and updated each term.

➔ Medication: _____

➔ Dose & frequency: _____

➔ Date of most recent hospitalisation: _____

➔ Name and contact details of Diabetic Resource Nurse: _____

_____

➔ Has your child needed emergency treatment for **hypoglycaemia**? ☐ NO ☐ YES

➔ Details: _____

_____

_____

Please indicate if your child suffers from the following:

☐ Migraine ☐ Skin disorders ☐ Excessive nosebleeds

☐ Head injury ☐ Lung problems ☐ Kidney or bladder problems

☐ Sinus trouble ☐ Heart problems ☐ Epilepsy or seizures of any kind

☐ Sleepwalking ☐ Recent bedwetting ☐ Anxiety or depression

☐ Earache/discharge ☐ Frequent colds ☐ Eye problems

☐ Phobias ☐ Social difficulties ☐ ADHD

☐ Asperger's Syndrome/Autism

➔ Details: _____

_____

_____

_____

_____

Is your child receiving any **specialist care?** (Please attach any relevant reports/documents)

➔ Details: _____

_____

_____

_____

Does your child require **medication?**

➔ Details: _____

_____

_____

_____

Does your child have any OTHER **medical condition, ongoing medical history** or **special treatments required?**

➔ Details: _____

_____

_____

_____

Does your child, or has your child had any **psychological, emotional or mental health issues?** ☐ NO ☐ YES

Has your child required treatment for any of the above? ☐ NO ☐ YES

➔ Details: _____

_____

_____

_____

Has your child required hospitalisation recently? ☐ NO ☐ YES

➔ Details: _____

_____

_____

_____

Is your child is up-to-date with all **childhood immunisations?** ☐ NO ☐ YES

Is your child is up-to-date with his/her **11 years vaccinations?** ☐ NO ☐ YES

Has your child been immunised against **Tetanus?** Date: / / ☐ NO ☐ YES

Has your child been immunised against **Hepatitis B?** Date: / / ☐ NO ☐ YES

Can your child swim 50 metres? ☐ NO ☐ YES

Is there any reason why your child may not be able to take a full and active part in the school programme (e.g. Physical Education)? ☐ NO ☐ YES

➔Details: _____

_____

_____

Does your daughter suffer from any menstrual problems? ☐ NO ☐ YES ☐ N/A

➔Details/medication required: _____

_____

Are there any other health and wellbeing issues that you would like to bring to the International Director/Dean/Hostel Managers attention? ➔ Details: _____

_____

_____

Parents will be contacted in the event that your child:

- Is injured.
- Becomes ill.
- Requires a stay in Hospital overnight.
- Requires medical treatment/specialist referral or follow up.

— DECLARATION —

I hereby give consent for the International Director/Dean or whoever is responsible in their absence, to access this information and to administer to (*name*) _____ **medication, covered by standing orders from a medical practioner, as required (e.g. pain relief; cough mixture; antihistamines; etc) or medication prescribed by a doctor, and/or first aid treatment, or be taken to Accident & Emergency if required.**

I understand that information, is critical in maintaining my child's safety, health and wellbeing and will be made available to appropriate staff members, in the interest of my child's safety.

I declare that the information provided is a true and accurate reflection of the record of my child's health and wellbeing.

Signature of Parent/Guardian: _____ Date: _____

The information you have supplied is required for the health and safety of your child. It is subject to the provisions of the Privacy Act and will be kept and used in a way that protects confidentiality. This form will be retained on file for medical information and consent for First Aid/treatment. If at any time this information changes, or you wish to alter your consent, please don't hesitate to contact the International Dean so that our records can be updated. Thank you. Email: international@wcc.school.nz