



Te Awamutu Primary School Student Health Profile



Student's Name: _____ Year Level: _____ Class: _____

Address: _____

Contact Phone Number: _____ Caregiver signature: _____

<p>1 Please tick if your child has any of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Migraine <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Travel Sickness <input type="checkbox"/> Fits of any type <input type="checkbox"/> Chronic nose bleeds <input type="checkbox"/> Heart Condition <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Colour Blindness <input type="checkbox"/> Other – Please specify <input type="checkbox"/> Sleep Walking <input type="checkbox"/> Bed/Sleeping Issues (Provide details below) <p>.....</p> <p>.....</p> <p>.....</p> <p>2 Medical Alert Number (if applicable)</p> <p>.....</p> <p>3 Date of last tetanus injection?</p> <p>...../...../.....</p> <p>4 Is your child currently taking medication?</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – Please state ailment/s <p>.....</p> <p>.....</p> <p>Name of medication/s</p> <p>.....</p> <p>.....</p> <p>Dosage & time/s to be taken</p> <p>.....</p> <p>.....</p>	<p>5 Has your child had any major injuries (breaks or strains) or illness (glandular fever etc.) in the last six months that may limit full participation in any activities?</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – Please specify <p>.....</p> <p>.....</p> <p>6 Is your child allergic to any of the following?</p> <p>Prescription medication</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – Please specify <p>.....</p> <p>.....</p> <p>Food</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – Please specify <p>.....</p> <p>.....</p> <p>Insect bites/stings</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – Please specify <p>.....</p> <p>.....</p> <p>Other allergies</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – Please specify <p>.....</p> <p>.....</p> <p>Treatment required?</p> <p>.....</p> <p>.....</p>	<p>7 Outline any dietary requirements?</p> <p>.....</p> <p>.....</p> <p>8 What pain/flu medication may your child be given if necessary?</p> <p>.....</p> <p>.....</p> <p>9 To the best of your knowledge, has your child been in contact with any contagious or infectious diseases in the last four weeks?</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – please give brief details <p>.....</p> <p>.....</p> <p>10 Is there any other information that staff should know to ensure the physical and emotional safety of your child? Eg. Cultural practices, disability, anxiety about heights/darkness/small places, behavioural or emotional problems)</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes – please give brief details <p>.....</p> <p>.....</p> <p>11 What is your child's swimming ability?</p> <ul style="list-style-type: none"> <input type="checkbox"/> 50 metres - freestyle <input type="checkbox"/> 100 metres - freestyle <p>Any comments about swimming ability?</p> <p>.....</p> <p>.....</p>
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Please contact your child's classroom teacher if you need to speak about any of the above.

Parents/Caregiver's Name:

Date:

Signature:

