

Hillcrest High School STUDENT HEALTH INFORMATION 2018

STUDENT INFORMATION		
Surname:	First name:	Date of birth:

The Hillcrest High School Health Clinic has a registered nurse present during school hours.

CONSENT: Please tick /

Permission for the school nurse or designated first aider to administer routine **over-the-counter** medication as required e.g. paracetamol, antihistamine cream/tablets, arnica cream, Rescue Remedy, throat lozenges and quick-eze and cough medicine

Yes No

Permission for the school nurse to give Nurofen (Ibuprofen)

Yes No

YOUR CHILD'S DOCTOR:

Name	Phone:
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YOUR CHILD'S DENTAL CARE:

Dental care is free to anybody under the age of 18 years who is enrolled with a contracting dentist. At Hillcrest High School students have the option of using the HHS contracted dental provider or enrolling with another contracting dentist. Please indicate your preference below:

HHS dental provider OR Your child's dentist: Name Phone:

YOUR CHILD'S PAST HISTORY OF OPERATIONS, ILLNESS, INJURIES, DISABILITIES (please give details):

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS? Please tick /

Asthma <input type="checkbox"/>	Depression <input type="checkbox"/>	Hay fever <input type="checkbox"/>	Migraines/Headaches <input type="checkbox"/>
Anxiety Problems <input type="checkbox"/>	Ear Infection <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Menstrual Problems <input type="checkbox"/>
Back/Neck Problems <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Heart Condition <input type="checkbox"/>	Recurring Abdominal Pain <input type="checkbox"/>
Cancer <input type="checkbox"/>	Eyesight Problems <input type="checkbox"/>	Hepatitis/HIV <input type="checkbox"/>	Skin Condition <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Fainting <input type="checkbox"/>	Kidney Problems <input type="checkbox"/>	Other (eg ADD) <input type="checkbox"/>

If yes, please give details and treatment information:

DOES YOUR CHILD CURRENTLY TAKE ANY MEDICATION/S (PRESCRIPTION OR OVER THE COUNTER, INCLUDING HERBAL)? (please give details)

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DOES YOUR CHILD HAVE ANY ALLERGIES AND/OR SENSITIVITIES? (please give details)

ALLERGY e.g. Peanuts, bee stings, medications	COMMENT (Severity) e.g. Severe: Anaphylaxis / Moderate: Swelling	TREATMENT e.g. Requires adrenalin, call ambulance, Phenergan, icepack

VACCINATIONS HISTORY Please indicate

Is your child's Tetanus up to date?	Yes	No	Date last given:.....
Are your child's childhood immunizations up to date?	Yes	No	Attach copy of immunization certificate

*Please note: Information provided on this form is available to all staff at Hillcrest High school.
Any concerns please contact the School Nurse, Dean or Guidance Counsellors.*

Parent/Caregiver's signature: _____ Date: _____