Mercury Bay Area School

Whitianga - Mercury Bay - The Coromandel Peninsula - New Zealand

Te Kura o Te Whanganui o Hei

Marine Academy Programme

Health profile and medical consent

Name: _____ Medic Alert Number: _____ (if applicable)

1. Please tick if you have any of the following:

- ☐ Migraine
- ☐ Epilepsy
- ☐ Asthma
- ☐ Diabetes
- ☐ Travel sickness
- ☐ Fits of any type
- ☐ Chronic nose bleeds
- ☐ Heart condition
- ☐ Dizzy spells
- ☐ Colour blindness
- ☐ Other (Please specify) _____
- ☐ ADHD

For overnight events

- ☐ Sleepwalking
- ☐ Bedwetting

2. Are you/your child currently taking medication? ☐ Yes ☐ No

If YES, please state: Health condition/s: _____

Name of medication/s: _____

Dosage and time/s to be taken: _____

Other Treatment: _____

3. Is a health plan required? ☐ Yes ☐ No

Have you 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? ☐ Yes ☐ No

If YES, please state the injury/illness:

_____

_____

_____

4. Are you allergic to any of the following?

	Yes	No	Please specify
Prescription medication	☐	☐	
Food	☐	☐	
Insect bites/stings	☐	☐	
Other allergies	☐	☐	

What treatment is required? _____

5. When was your /your child's last tetanus injection? _____

6. Outline any dietary requirements:

_____

_____

_____

_____

7. What pain/flu medication may your child be given if necessary?

_____

_____

_____

_____

8. To the best of your knowledge. Have you/your child been in contact with any contagious or infectious diseases in the last four weeks?

☐ Yes ☐ No

If YES, please give brief details

_____

_____

_____

9. Is there any information the staff should know to ensure the physical and emotional safety of you/your child? (For example cultural practices; disability; anxiety; about heights/darkness/small spaces; pregnancy; behaviour or emotional problems).

☐ Yes ☐ No

If YES, please state or attach the information.

_____

_____

_____

Tick

☐ I agree that if prescribed medication needs to be administered, a designated adult will be assigned to do this. I will ensure that prescribed medication is clearly labelled, securely fastened and handed to the designated adult with instructions on its administration.

☐ I will inform the school as soon as possible of any changes in the medical or other circumstances between now and the commencement of the event.

☐ I agree to my child/myself receiving any emergency medical, dental, or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

☐ Any medical costs not covered by ACC will be paid by me.

☐ If my child is involved in a serious disciplinary problem, including the use of illegal substances and/or alcohol, or actions that threaten the safety of others, s/he will be sent home at my expense.

To be read and signed by adult participant or parent/caregiver of child participant.

Signature: _____

Name: _____ Date: _____

Parent Information

Name: **Home phone:**

Address:

Email: **Cell phone:**

Emergency Contact(s)

Name: **Home phone:**

Email: **Cell phone:**