

# McAuley High School

## STUDENT SUPPORT CONSENT FORM

### STUDENT DETAILS

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### SPECIAL NEEDS

Please describe any health or learning difficulties your daughter has to enable us to better meet these special needs.

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**HAS YOUR DAUGHTER RECEIVED ANY SPECIAL LEARNING ASSISTANCE?** Yes / No

If yes, please list e.g. ORS Funding, ACC, Teacher Assistant, RTL

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**HAS YOUR DAUGHTER RECEIVED ANY EXTERNAL SUPPORT?** Yes / No

If yes, please list, e.g. OT, Whirinaki, Kari, Social Worker, Psychologist, etc

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### EYESIGHT AND HEARING

Does your daughter require, or has she in the past required glasses? Yes / No

Has your daughter ever been assessed for hearing difficulties? Yes / No

### MEDICAL INFORMATION

Does your daughter suffer from, or has she in the past suffered from:

Heart Condition	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Allergies	<input type="checkbox"/>

Please state allergies: \_\_\_\_\_

Please state any dietary requirements (e.g. vegan): \_\_\_\_\_

### STUDENT'S DOCTOR

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

MEDICAL CENTRE: \_\_\_\_\_

### DENTAL TREATMENT

Do you wish to register your daughter with the dental provider that visits the school? Yes / No

## IMMUNISATION

Has your daughter received childhood immunisations? **Yes / No**

Proof of Immunity provided, (Immunisation Certificate or Well Child/Plunket Book) **Yes / No**

## CONSENT

I/we give consent to the following:

1. For my daughter to have access to the range of services provided by the staff of the Student Health and Guidance Centre, i.e. Nurse, Guidance Counsellor, Social Worker, Psychologist, Physiotherapist.

I understand that these people will provide a range of health and guidance services. **Yes / No**

2. For my daughter to be interviewed by the School Nurse to establish any health needs that may affect her learning. This information will be confidential. This discussion covers:

- visits to a GP
- health and wellbeing factors relating to home, school and friends
- interests outside of school.

**Yes / No**

3. I give consent for my daughter to be given:

Paracetamol **Yes / No**      Antihistamine/Allergy Tablets **Yes / No**      Ibuprofen **Yes / No**

If you give your consent to any of the items above it would be useful for us to know of any risk factors that may influence your daughter's health. Please tick the following boxes if a **FAMILY MEMBER** has any of these illnesses.

Diabetes	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Meningococcal Disease	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>

**\* The school nurse may contact you to discuss any decisions you may not consent to.**

Signed \_\_\_\_\_

Date \_\_\_\_\_