

Health and Consent Form - KIRIKIROA NOHO MARAE EOTC

This form must be accompanied by an information sheet listing all activities the student will be participating in as part of the EOTC event. Details on this form will remain confidential to school staff and other adults associated with supervising activities on the event. This form or a copy must be taken on the event.

KAIAKO: Rawiri Blundell	AKOMANGA: 21	Dates: Thurs 26 - Fri 27 Mar
Event: KIRIKIROA MARAE NOHO	Location: 951 Wairere Drive, Hamilton East, Hamilton 3216 (behind kura)	
NAME OF CHILD		

Name of parent / caregiver:		
Address:		
Phone (day)	(evening)	(mobile)

EMERGENCY CONTACT DETAILS

Name:		
Relationship to child:		
Phone (day)	(evening)	(mobile)

HEALTH and MEDICAL INFORMATION

Please tick if your child has any of the following:			
<input type="checkbox"/> migraine	<input type="checkbox"/> epilepsy	<input type="checkbox"/> asthma	<input type="checkbox"/> diabetes
<input type="checkbox"/> sinus problems	<input type="checkbox"/> hay fever	<input type="checkbox"/> other (please specify)	
Treatment required?			

Please tick if your child is allergic to any of the following and provide details of treatment required if any.	
<input type="checkbox"/> prescription medicine	_____
<input type="checkbox"/> insect bites/stings	_____
<input type="checkbox"/> other allergies (state)	_____

Is there any other information the staff should know to ensure the physical and emotional safety of your child?	
e.g. <input type="checkbox"/> bed wetting <input type="checkbox"/> sleepwalking <input type="checkbox"/> cultural practices <input type="checkbox"/> anxieties (e.g. darkness, unfamiliar surroundings)	
If YES, please give details:	

Does your child currently take any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, please state:	Ailment/s:
	Name of medication:
	Dosages and times to be taken:
	Other treatment:

Please tick any dietary requirements relevant for your child	
<input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Halal <input type="checkbox"/> Dairy free	<input type="checkbox"/> Gluten free <input type="checkbox"/> Food allergies - please provide details below <input type="checkbox"/> Other - e.g nuts, eggs etc please specify below
Is there anything else we need to know about your child's dietary needs...	

When was your child's last tetanus injection?	
What pain medication may your child be given if necessary?	

To the best of your knowledge, has your child been in contact with any contagious or infectious disease in the last four weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please give brief details:

CONSENT INFORMATION - Please tick boxes and sign below:

- Tick
- I approve of my child taking part in this event, and have read the information sheet.
 - In the event of an accident or illness, I agree to my child receiving any emergency medical, dental or surgical treatment as, in the opinion of a staff member, assisting parent or a medical professional, may be required.
 - Any medical costs not covered by ACC or a community service card will be paid by me.
 - 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 given to the teacher with instructions on its administration.
 - I understand and agree that the designated adult will make their "best effort" to administer the medication as directed and if they are inadvertently unable to, then I will take no action against them.
 - If at some time in the future it is discovered that the medication has side effects, I will not take any action against the school administering the medication.

Signed:	Date:
Caregiver name:	