MASTERTON
INTERMEDIATE SCHOOL

Dear Parents/Caregivers

Our Public Health Nurse, Danica Goldsmith will be visiting MIS on a regular basis to promote good health within our school and the wider school community.

Danica will also be running a "drop-in" school clinic on Wednesdays when she is not vaccinating. This clinic will give the student, yourselves and teachers the opportunity to address any concerns in relation to the pupil's physical and mental health eg head lice, school sores, skin conditions.

Danica welcomes your referrals for the clinic and you can pass these into the school office. Your child is also welcome to attend the "drop-in" clinic of their own free will, or be referred by their teacher. After the consultation Danica will telephone you, or send a note home with your child, outlining the visit and its outcomes, along with advice to assist you in accessing appropriate services should they be required.

In order for the school "drop-in" clinic to run smoothly please complete the form below and send it back to the school office.

Yours sincerely

Russell Thompson
Principal

✂.....

Please complete and return to the school office

- I ***consent*** to my child / children being seen at school by the Public Health Nurse ☐
- I ***do not consent*** to my child / children being seen at school by the Public Health Nurse ☐

Child / Children's Names .....

Room No(s) .....

Parent / Caregiver .....

Signature .....

Address .....

Telephone No. (Evening) ..... (Daytime).....

Date.....

Non Consent / Withdrawal from Service

- ☐ I do not consent for my child / children to have any care as provided by the School Dental Service.
- ☐ I wish to withdraw my child / children from the School Dental Service.

- I accept that the Dental Therapist and their employer cannot be held responsible for any condition, which may arise as a consequence of my refusal of giving my consent.
- I understand that dental care provided for my child by a private dental practitioner would be ***at my own expense.***

Name of Child / Children:

.....

.....

.....

.....

....

Signature Please print your name Date

Community Dental Clinic
MIS Grounds
Intermediate Street
Masterton 5810

Ph: 06 377 9071
Fax: 06 377 9072

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

ENROLMENT FOR ORAL HEALTH SERVICE

The School Dental Service provides free dental examinations and care for children from birth to the end of Year 8. It has a commitment to informing patients / parents of treament options.

CHILD .....
Surname First Name(s)

CHILDS NHI NUMBER .....

PARENT/S / CAREGIVER/S

.....
Surname First Name/s

.....
Surname First Name/s

Current School .....

Previous School / Pre-school .....

DOB ..... **Male / Female**

ADDRESS .....

.....

PH: Home..... **Mobile** .....

PH: Work: .....

ALTERNATIVE CONTACT: **Name**.....

Phone .....**Relationship to child**.....

MEDICAL HISTORY

This information is kept confidential

Does your child have any disabilities eg hearing, sight, speaking, physical or mental health, learning or remembering?

.....

Some medical conditions and some medicines affect dental care. Please answer the question below:

Has your child ever had?

		Yes	No
☞ Bleeding trouble		❑	❑
☞ Rheumatic Fever		❑	❑
☞ A Heart Condition		❑	❑
☞ * requires antibiotics for dental treatment		❑	❑
☞ Diabetes		❑	❑
☞ Epilepsy		❑	❑
☞ Hepatitis	A	❑	❑
☞	B	❑	❑
☞	C	❑	❑
☞ Asthma		❑	❑
☞ Has your child any other medical conditions?		❑	❑

If yes please specify: .....

☞ An allergy to medication or other substance ❑ ❑

If yes please specify: .....

☞ Name of family doctor if any: .....

☞ Is your child taking any pills or medication prescribed by a doctor? ❑ ❑

If yes please state the name of the medication (it is usually written on the bottle): .....

☞ Reason for taking medication: .....

Has your child been enrolled at any other Dental Clinic outside of the Wairarapa? ❑ ❑

If so, please give Clinic name and address:

.....

ETHNIC ORIGIN

We need the following information for health statistics only.

~~Which cultural heritage does your child belong to?~~
Please tick box that applies.

NZ Maori ❑ NZ European ❑ Pacific Island ❑

Other (Please specify) .....

Please sign the following:

Enrol with the Oral Health Service for free care.

I understand my child is enrolled with the school Dental Service and will receive an **annual examination which may require an x-ray.** Should any further treatment be necessary my signed consent will be required.

I also give consent for my child's dental records to be passed on to subsequent dental clinics my child attends so that continuity of care can be provided.

I also give consent to the School Dental Service to obtain my child's NHI number.

....

Signature of Parent / Caregiver Date

We undertake:

- to inform you of what needs to be done to keep your child's mouth healthy
- to make you welcome at any appointment
- to take note of your particular treatment preferences

BRING YOUR OWN DEVICE (BYOD) AGREEMENT

Note: This agreement is **additional** to the student digital technology agreement. It refers to digital devices brought to school by students, and must be signed before the student may bring the device to school.

To the parent/caregiver/legal guardian, please:

1. Read this page carefully with your child, to check that you both understand your responsibilities under this agreement.
2. Sign the appropriate section on this form.
3. Detach and return the signed section to the school office.
4. Keep this document for future reference.

School Responsibilities

At our school, we will:

- encourage safe and effective use of technology and the internet
- work within the school's digital technology guidelines
- provide clear guidelines around the use of devices brought from home
- provide safe storage for students' devices when not at use, e.g. break times.

If a student breaches the BYOD agreement, they may lose the privilege of bringing their own device to school, and the school's behaviour management plan may be invoked.

Student Responsibilities

When I bring my device to school I will:

- follow the school's digital technology rules
- use my device when and where the teacher gives me permission
- only access the internet with the teacher's permission and if an adult is present
- only use my own login and password
- be in control of my device and not share it with other students, apart from letting them see the screen
- charge my device at home so that it doesn't need charging at school
- take care of my device so that it isn't damaged or stolen.

I will not use my device to be mean, rude, or offensive to anyone.

Parent Responsibilities

I give permission for my child to bring their device to school and I will:

- encourage them to use it responsibly
- take an interest in how they are using the device
- be aware of the content and applications on the device
- be responsible for the device's maintenance and insurance
- keep a record of the device's serial number and details
- contact the school if I have any concerns about cybersafety or other related issues.

Note: This agreement for your child will remain in force as long as he/she is enrolled at this school. If it becomes necessary to add/amend any information or rule, parents will be advised in writing.

Please detach and return this section to school.

I have read this Bring Your Own Device (BYOD) use agreement, and I am aware of the school's initiatives to maintain a cybersafe learning environment, including my child's responsibilities.

Student's name _____ Student's signature _____

Parent/caregiver/ legal guardian's name _____ Parent's signature _____

Date _____

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