MEDICAL FORM

Student

Student's surname IN BLOCK LETTERS

.....

First names

PLEASE UNDERLINE NAME BY WHICH STUDENT IS CALLED

.....

Address

.....

.....

.....

Sex Male/Female

.....

Date of birth

.....

Town and country of birth

.....

If born outside UK, date when first entered UK

.....

Nationality

.....

Date of school entry

.....

Year Group

.....

Father NAME IN BLOCK LETTERS

.....

Telephone

Home: .....

Office: .....

Mobile: .....

Mother NAME IN BLOCK LETTERS

.....

Telephone

Home: .....

Office: .....

Mobile: .....

Other emergency contacts

(Must be within a 30 minute pick up area of the school)

Contact One

NAME IN BLOCK LETTERS

.....

Telephone

Home: .....

Office: .....

Mobile: .....

Contact Two

NAME IN BLOCK LETTERS

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Telephone

Home: .....

Office: .....

Mobile: .....

GP Name and Address

(in case of emergency only)

NAME IN BLOCK LETTERS

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Telephone

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Surgery Address:

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Next of kin

(If not a parent or guardian)

NAME IN BLOCK LETTERS

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Address

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Telephone

Home: .....

Office: .....

Mobile: .....

Immunisations

Primary Child Immunisations

Diptheria/Tetanus/Pertussis/Polio & Hib

1st dose date……

2nd dose date……..

3rd dose date……

Pneumococcal

1st dose date……

2nd dose date……..

Men C

1st dose date……...

12 Month Immunisations

Hib booster

Date……

…

Men C booster

Date……

…

Pneumococcal booster

Date……

MMR 1st dose

Date……

…

Influenza immunisation/nasal spray

Date……

…

Pre School Boosters *Diptheria/ Tetanus/Pertussis/Polio1*

Date……

….. MMR 2nd Dose

Date ……..

HPV

1st dose date……

2nd dose date……

Year 9

Diptheria/Tetanus/Polio

Date…… Men

ACWY

Date……...

Medical History

Has your child suffered from any of the following? If "Yes", please give dates and details.

Asthma *Yes No*

If yes when was your last asthma review and what medication are you regularly prescribed?

……

……

Drug allergies *Yes No*

If Yes please write below the drug and symptoms:

……

Other allergies (e.g. food) *Yes No*

If yes please write below the food substance and symptoms:

……

Does your child carry an Auto adrenalin injector pen? *Yes No*

Hay Fever *Yes No*

Heart problems *Yes No*

Migraines *Yes No*

Epilepsy *Yes No*

Diabetes *Yes No*

Eczema *Yes No*

Any other medical conditions:

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Please note as per school policy:

- *All students with diagnosed asthma must carry their blue inhaler around with them at all times*
- *All students who have been prescribed an auto adrenaline injector (AAI) pen must carry 2 pens with them at all times.*

Junior school:
These are to be handed in to teaching staff.

(Salbutamol inhalers and generic AAI pens are kept in the health centre and boarding houses for emergency use)

***Boarders:** please provide a copy of vaccination certificates.*

Further details

Does your child wear glasses or contact lenses? *Yes No*

Date eyesight last tested ……..
(Advised every 12 months)
Date last Dentist appointment
(Advised every 2 years)
……..

Is your child receiving Orthodontic treatment?
Yes No

Is your child fit to take part in the normal school routine, both work and sport?
Yes No

Has your child ever had an operation?
Yes No

Has your child ever suffered from anxiety, depression or any other mental health illness?
Yes No

Has your child ever been referred to a Child Guidance Clinic or psychologist?
Yes No

Has your child ever had an eating disorder?
Yes No

Is there any history of drug or alcohol abuse? *Yes No*

Is your child undergoing current treatmentfor any medical condition? *Yes No*

Is your child undergoing current treatment for any psychological problem?
Yes No

If the answer to any of the above questions is 'Yes' please give further details including dates.

Does your child take any regular prescribed

Other information

Please give details of any relevant family history of high blood pressure, epilepsy, diabetes, any other hereditary or familial disorders or psychiatric illnesses, or any other information which the school should be aware of or which would prove useful.

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medication? If yes please state name and dose

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Consent

I give my consent for any necessary medical and emergency treatment to be carried out while my child is at school. This may include the administration of over- the-counter (OTC) medications (please see OTC list).

Signed: .....

Date: .....

Relationship to student:

.....

To be completed by boarders only.

NB While your child is a boarder, he/ she will be registered with the school Doctor. Should your child require medical attention during the holidays he/she should be registered as a temporary resident at home.

NHS number (if known)

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Private medicalinsurance

Does your child have private medical insurance?

Yes No

If so please give details:

The insurance company:

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Your child's membership number:

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Contact details for the company:

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To be completed by overseas parents only.

UK appointed Guardian:

NAME IN BLOCK LETTERS

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Telephone

Home: .....

Office: .....

Mobile: .....

Email: .....

Address: .....

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