Medical Information

|  |  |
| --- | --- |
| Name of child: | Date of birth: |

|  |  |
| --- | --- |
| **RECORD OF IMMUNISATIONS:** | |
| **TYPE** | **DATE** |
| Diptheria, tetanus, whooping cough, polio |  |
| Haemophilius influenza type B (Hib) |  |
| Pneumoccoccal infection |  |
| Meningitis C |  |
| Measles, Mumps, rubella |  |
| (Girls only) Cervical cancer |  |
| Heaf Test |  |
| BCG |  |

|  |  |
| --- | --- |
| **PLEASE GIVE DETAILS OF THE FOLLOWING:** | |
| Any allergies or sensitivities to food, medication, pets or to insect stings? | Yes [ ] No [ ] |
| Details: |
|  |
|  |
|  |
| Any chronic or recurring medical conditions needing regular or occasional medication or treatment? | Yes [ ] No [ ] |
| Details: |
|  |
|  |
|  |
| History of any serious illnesses or injuries requiring admission to hospital? | Yes [ ] No [ ] |
| Details: |
|  |
|  |
|  |
| Any other conditions that might affect your child in his or her school life? | Yes [ ] No [ ] |
| Details: |
|  |
|  |
| Are there any psychological factors that affect your child of which we should be aware? | Yes [ ] No [ ] |
| Details: |
|  |
|  |
|  |
| Does your child have regular dental checks? | Yes [ ] No [ ] |
| Does he/she wear a dental appliance? | Yes [ ] No [ ] |
| Details: |
|  |
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|  |
| Does your child have regular eye tests? | Yes [ ] No [ ] |
| Does your child require glasses? | Yes [ ] No [ ] |
| Details: |
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| Do you have private medical insurance? | Yes [ ] No [ ] |
| Please give details of any family bereavement issues that the school should be aware of: |  |
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Are there any circumstances relating to your child of which the school should be aware? Please check as appropriate:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ADHD |  | Allergies |  | Aspergers Syndrome | |  |  |
| Autism |  | Dyslexia |  | Dyspraxia | |  |  |
| Hearing impairment |  | Visual impairment |  | Asthma | |  |  |
| Hay fever |  | Migraines |  |  | |  |  |
| Please enclose the most recent Education Psychologist’s report, if applicable. | | | | | | | |
| Other (please give details): |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |
|  |  |  |  | |  |  |  |

**Emergency Contact Details**

|  |  |
| --- | --- |
| **Family Doctor:** | **Family Dentist:** |
| Address: | Address: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Telephone: | Telephone: |
| Mobile: | Mobile: |
| E-mail: | E-mail: |

|  |  |
| --- | --- |
| **Mother:** | **Father:** |
| Business Address: | Business Address: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Business telephone: | Business telephone: |
| Mobile: | Mobile: |
| E-mail: | E-mail: |

**Consent to General Treatment and First Aid**

I/We\* give consent for my/our\* child receiving all the general health care and first aid services provided at Hopelands Preparatory School under the supervision of a trained First Aider.

He/she\* may/may not\* be given first aid treatment by any qualified member of staff.

He/she\* may/may not\* be given non-prescribed medicines to treat minor illness or injury.

*(Parents of EYFS pupils will be asked to give written consent on each occasion that medication is administered).*

**Consent to Emergency Treatment**

I/We\* authorise the Head, or an authorised deputy acting on their behalf to consent on the advice of an appropriately qualified medical specialist to my/our\* child receiving emergency medical treatment including general anaesthetic and surgical procedure (under the NHS) if the school is unable to contact me/us\*.

*\*Please delete as appropriate*

|  |  |  |  |
| --- | --- | --- | --- |
| **First signature:** |  | **Second signature:** |  |
| Name in full: |  | Name in full: |  |
| Relationship to child: |  | Relationship to child: |  |
| Date: |  | Date: |  |