Abbotsholme School Pupil Medical Record

School Entry Date:

Surname	First Name	Nationality	Date of Birth

Address	Family Doctor
Tel No: Mobile No:	Name Address Tel No:

Has your child ever suffered from the following: (Please give approximate age where appropriate)

Childhood Illness'		**AGE**
Measles	YES/NO	_____
Chicken Pox	YES/NO	_____
Jaundice	YES/NO	_____
Rheumatic Fever	YES/NO	_____
Glandular Fever	YES/NO	_____

SKIN DISEASES		**AGE**
Eczema/Dermatitis	YES/NO	_____
Psoriasis	YES/NO	_____
Others	YES/NO	_____
_____		_____

MISCELLANEOUS		**AGE**
Ear Disease	YES/NO	_____
Hay Fever	YES/NO	_____
Perennial Rhinitis	YES/NO	_____
Congenital Disease	YES/NO	
Incontinence /Bedwetting	YES/NO	_____

Diabetes	YES/NO	
Epilepsy	YES/NO	
Peptic Ulcer/Gastric Trouble	YES/NO	
Migraine	YES/NO	

TROPICAL DISEASES		**AGE**
Malaria	YES/NO	_____
Dysentery	YES/NO	_____
Other	YES/NO	
_____		_____

EYE CONDITIONS		**DATE**
Need for Glasses (Since)		_____
Previous Squint Operation		_____
Colour Blindness	YES/NO	
Contact Lenses	YES/NO	

MAJOR INJURIES		**AGE**
E.g. Fractures	YES/NO	_____
_____		_____

OPERATIONS		**DATE**
Tonsillectomy	YES/NO	_____
Appendectomy	YES/NO	_____
Other	YES/NO	
_____		_____

Does your child have private health cover? Yes / No

ADDITIONAL INFORMATION

Is your child asthmatic? Yes/No If Yes what medication and dosage is he / she taking?

Any other medication? Yes/No Name dose and frequency.

Is your child able to self-medicate? Yes/No If yes please sign to confirm your consent_____

It would help if a spare supply of labelled prescribed medications for conditions such as Asthma, Migraine or Allergies could be kept in the medical room in case your child forgets to bring their medication in with them.

IMMUNISATION RECORD

Please enter most recent immunisation **DATE** for each vaccine. This is information that we do require.

Tetanus	_____	MenACWY	_____	Yellow Fever	_____
Polio	_____	BCG	_____	Hepatitis A	_____
Diphtheria	_____	MMR	_____	Hepatitis B	_____
		HPV	_____	Typhoid	_____
Any Other			_____		
_____	_____		_____		

FAMILY

Is there any serious illness in the family? (Please circle if appropriate)

Asthma	Sickle Cell or Thalassemia	Diabetes	Eczema	Hay Fever	Migraine

FAMILY CIRCUMSTANCES

Please give any details of family breaks, emotional problems or any other information which you feel may affect your child

ALLERGIES

Does your child have any allergies? Yes / No If Yes what treatment do they require?

It is important that you inform us of any allergy that your son and daughter may have and the required treatment.

Are there any points about your child's health that School should be aware of? Any additional information

BOARDING CHILDREN

Are you willing for immunisation against Tetanus, Polio, Diphtheria to be updated when necessary YES/NO

Parent/Guardian signature _____

Relationship to Child _____

DAY & BOARDING

You will be notified in writing about any other immunisation e.g. BCG for your consent to this procedure.
It may be necessary to treat your child for minor illness or ailments whilst they are at school. We would of course contact you if there was a need for your child to receive medical care. This would give you an opportunity to take your child to your own Doctor. If we are unable to contact you or if you are in agreement we may then either arrange an appointment at the surgery of our nominated Medical Officer, Dr Helen Maxwell-Jones, Ashbourne, (*this applies to boarding pupils only)* or at a Hospital*, (again this applies to boarding students only)*. If you are in agreement with this then please sign the form as appropriate and return to school at your earliest convenience.

I do / do not consent to my child being treated in the case of minor injuries / ailments.

Parent / Guardian signature …… Date: ……

If you do not give permission for your child to be treated as above then we presume that you will collect your child from school in the event of a minor illness or ailment.

The person to contact in the event of illness or injury is:

Name: …… Relationship ……..

Address: …….

……..……...

Tel No: ……. (home) …… (work)

Mobile: ……..

In the event that the above person is not available please contact:

Name: …… Relationship ……..

Address: …….

……..……...

Tel No: ……. (home) …… (work)

Mobile: ……..

Name: …… Relationship ……..

Address: …….

……..……...

Tel No: ……. (home) …… (work)

Mobile: ……..

In providing medical and nursing care for a pupil, it is recognised that on occasions the School Health Advisor and Medical Officer may liaise with the Head and other appropriate adults as necessary, and that information ideally with the pupil's prior consent will be passed on as necessary. With all medical and nursing matters the School's Health Advisor and Medical Officer will respect a pupil's confidence except on the very rare occasions when, they consider that it is in the pupil's better interests or necessary for the protection of the wider school community, to pass information to a relevant person or body.

The School's Health Centre maintains a medical health and illness record to be able to give appropriate help and advice to pupils and staff. The information on this form is for that purpose and the answers will remain confidential to the Health Centre and appropriate staff where relevant.

This form should be returned directly to the Health Centre. This will maintain confidentiality.

Parent's Signature_____ Date_____

Health Centre, Abbotsholme School, Rocester, Nr. Uttoxeter, ST14 5BS