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***Medical Questionnaire***

***New Day Pupils***

***Prep School***

***PRIVATE AND CONFIDENTIAL***

*Please return this booklet direct to the*

*Medical Centre*

**Confidential Medical Report – New Prep School Day Pupil**

**It is *essential* that this booklet is completed fully including the record of immunisation and returned to the School Medical Centre BEFORE your child joins the school so that up-to-date information is available to the medical staff. The information will be kept on the confidential school medical health database (accessible only to the medical staff at Kent College).**

REGISTRATION: All boarding pupils will be placed on the NHS list of the School Medical Officer in order that prompt assessment and treatment of any illness or injury that cannot be managed in the school Medical Centre, is obtained. During school holidays medical treatment can be sought either privately or under the National Health Service Act as a 'temporary resident'.

CONSENT TO EMERGENCY TREATMENT: If a pupil requires urgent medical treatment within school or whilst on a school trip, every effort will be made to obtain the prior consent of the parent or guardian. Should this prove impossible in the time available, the Headmistress, acting in loco parentis, or her representative, is authorised to give valid consent to such treatment (including anaesthetic or surgical procedure) as may be advised by the School Medical Officer or Hospital Consultant.

IMMUNISATION: All pupils entering the school are expected to be up-to-date with routine immunisations according to the Department of Health guidelines. Immunisations will not be given without written consent of parent/guardian.

INFORMATION: All medical information disclosed on this form will be treated in the strictest confidence and shared only with relevant staff on a need-to-know basis, e.g. allergies, serious medical conditions.

Please answer all questions in as much detail as possible in order for us to be able to fully support and care for your child.

Child's Name: ………………………………………………………… Date of Birth: ………………………………………………………

NHS Number (if known): …………………………………… Place of Birth: ………………………………………………………

Name, Address & Tel No. of current GP: ………………………………………………………………………………………………

*Immunisation History*: PLEASE COMPLETE INFORMATION BELOW IN FULL or include a photocopy of immunisation record

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Date 1 | Date 2 | Date 3 | Date 4 | Date 5 |
| Diphtheria |  |  |  |  |  |
| Tetanus |  |  |  |  |  |
| Pertussis (Whooping Cough) |  |  |  |  |  |
| Poliomyelitis |  |  |  |  |  |
| Hib (Haemophilus Influenza b) |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| Meningococcal B (MenB) – only infants born on or after 1 May 2015 |  |  |  |  |  |
| Meningococcal C (MenC) |  |  |  |  |  |
| Measles Mumps & Rubella |  |  |  |  |  |
| BCG |  |  |  |  |  |
| HPV (girls & boys 12 to 13yrs) |  |  |  |  |  |
| Meningitis ACWY |  |  |  |  |  |
| Hepatitis A |  |  |  |  |  |
| Japanese Encephalitis |  |  |  |  |  |
| Typhoid |  |  |  |  |  |
| Yellow Fever |  |  |  |  |  |
| Other – please specify |  |  |  |  |  |

***Medical History***

Does your child suffer from any of the following (**if YES** please tick box and give details of treatment, medication and severity). **Please advise if your child carries an adrenaline auto injector (Epipen, Jext) and/or an inhaler**

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergies** | [ ]  |  | * **Does your child have an adrenalin Auto Injector (Epipen, Jext)? YES / NO**

*Please enclose treatment plan** If YES – **I consent** to my child being treated for a severe allergic reaction using an emergency adrenalin auto injector, in the event their own is unavailable.

 **YES / NO**  |
| **Asthma** | [ ]  | Please indicate triggers and current medication:  | * If YES – **I consent** to my child being treated for asthma using an emergency salbutamol inhaler in the event their own is unavailable.

 **YES / NO**  |
| **Diabetes** | [ ]  | If YES: **INSULIN DEPENDENT / NON-INSULIN DEPENDENT** |
| **Eczema (or other skin condition)** | [ ]  |  |
| **Epilepsy/ convulsions** |[ ]   |
| **Migraine** |[ ]   |
| **Frequent sore throats or ear problems** |[ ]   |
| **Appendicitis / Appendectomy** | [ ]  |  |
| **Urinary issues e.g. weak bladder, enuresis, cystitis or recurrent infections** | [ ]  |  |
| **Vision/ Hearing problems** | [ ]  |  | Does your child wear spectacles?…………………………………………… |
|  |  |  | When was their last optician’s appointment?…………………………………………… |
| **Dental issues / orthodontic treatment** | [ ]  |  | When was their last dental appointment?…………………………………………… |
|  |  |  | Does your child have orthodontic braces fitted?…………………………………………… |
| *Care cannot be transferred between NHS orthodontists. Emergency appointments can be made but are with a private orthodontist, so a fee would be incurred.* |

|  |  |
| --- | --- |
| **Specific Dietary requirements** (include allergies and food intolerances) | ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |

|  |  |
| --- | --- |
| **Please give details of any other relevant information** (e.g. hospital admissions, operations, congenital abnormalities, medical conditions) **which may affect your child during their time at school or prevent them from taking part in normal school activities.** | ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |

Has your child suffered with any of the following? (Delete as appropriate). If **YES**, please provide approximate dates.

|  |  |  |  |
| --- | --- | --- | --- |
|   | Date |  | Date |
| Measles  | YES/NO |  | Rheumatic Fever  | YES/NO |  |
| Chicken Pox  | YES/NO |  | Scarlet Fever  | YES/NO |  |
| Whooping Cough  | YES/NO |  | Glandular Fever  | YES/NO |  |
| German Measles  | YES/NO |  | Diphtheria  | YES/NO |  |
| Mumps | YES/NO |  |  |  |  |

***Emotional Wellbeing***

|  |
| --- |
| **Has your child ever experienced or been diagnosed with any of the following? (please tick as appropriate)** |
| * Anxiety
* Depression/low mood
* Insomnia
* Eating Disorder
* Self-harm
* Relationship difficulties
 | * ADHD (Attention Deficit Hyperactivity Disorder)
* ADD (Attention Deficit Disorder)
* ASD (Autistic Spectrum Disorder)
 |
| Has your child seen a GP, Psychiatrist, Psychologist or Counsellor in the past? YES / NO |
| Has your child been prescribed any medication for any of the above? YES / NO |
| If you have answered ‘yes’ to any of the above, please give full details:……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |

|  |  |
| --- | --- |
| **Does your child take any regular medication?**  If **YES,** please give details (with dosages) | …………………………………………………………………………………………………………………………………………………………………………………………………………………… |

**ALL medicines brought into school must be given to the School Nurse or Prep Reception. This includes over the counter (OTC) medicines. All medicines must be clearly labelled, with your child’s name and must be in their original container. Prescription medication must be in its original container from the Dispensing Pharmacy and have the name of the patient and administration information clearly written on it.**

***Medical and Emergency Consents***

* In the event of illness or injury I consent for my child to receive first aid and/or appropriate medical treatment from the School Nurse or a trained member of staff, as required.

 **YES / NO**

* I consent to a trained member of staff giving my child Paracetamol and/or antihistamines on a trip outside school, should the need arise.

 **YES / NO**

* Prep School holds a supply of over-the-counter, non-prescription medications. These medicines will only be administered to your child if we have your permission.

I consent for my child to receive the following over-the-counter medicines, under the direction of the School Nurse, should he/she become unwell or injured. **(Please tick to indicate consent)**

 ***Painkillers For allergies/hayfever*** 🞏 Paracetamol Suspension 🞏 Piriton (Chlorphenamine Maleate)

 🞏 Ibuprofen Suspension 🞏 Cetirizine Dihydrochloride (Piriteze)

***Creams and lotions***

🞏 Anthisan (cream for bites or allergy)

 🞏 Bite/sting relief spray

🞏 Arnica (for bruises)

* In the event of an accident or emergency, I hereby give consent to the Headmistress or her representative acting in ‘loco parentis’, to give permission to the medical authorities, on their advice, for the administration of an anaesthetic or operation or both. Parents will of course be notified of any such accident or emergency as soon as is practicable.

 **YES / NO**

|  |
| --- |
| **Declaration**I confirm that the information on this form is correct and that I have disclosed all relevant information that might affect my child’s health and welfare at Kent College |
| Parent signature: | Printed name in full: |
| Relationship to the child:  | Date: |

*Parents are reminded that the School Nursing Sister should be informed IMMEDIATELY of any changes in their child’s health or medication.*

Please use this space for any additional medical information