

MEDICAL HISTORY FORM
PLEASE COMPLETE AND RETURN TO OFFICE

BOUNDARY OAK SCHOOL Date:.....



NAME: D.O.B.:/...../.....

DOCTORS Name and address:.....

.....

..... NAT. HEALTH NO:.....

Emergency Contact Name (not parents).....

Relationship to child..... Telephone:.....

Medical History – please complete in full:

1. Have they had: Measles? German Measles?
Chickenpox? Mumps?

2. Do they suffer from any allergies: Asthma? Eczema?
Hay Fever Other?

3. Do they have a normal diet? Is there any foodstuff to which they are known to be allergic to? YES / NO
(If yes, please give details here)

4. Do they currently take regular medication of any kind? (If yes, please give details here) YES / NO

5. Do they have particular advice to follow in an emergency? (If yes, please give details here) YES / NO

6. Is there any drug or medication (e.g. plasters or Penicillin) to which they are known to be allergic YES / NO
(If yes, please give details here)

8. Do they receive regular treatment from a family doctor or hospital? YES / NO
(If yes, please give details here)

9. Is their hearing normal? (If no, please give details) YES / NO

10. Is their eyesight good? (If no, when were his/her eyes tested?) YES / NO
Do they wear or need glasses?

11. Have they had a surgical operation? (If yes, please give details here) YES / NO

12. Have they had any medical investigations? e.g. x-rays, pathological tests. etc. YES / NO
(If yes, please give details here)

13. Have they suffered from any other significant illness or is he/she disabled in any way? YES / NO
(If yes, please give details here)

14. Do they sleep walk, have problems sleeping (nightmares/terrors) or regularly wet the bed? YES / NO
(Please give details here)

15. Is there any other information you think we should know about your child?

16. Have they ever suffered from the following?

Blood disorder	YES / NO	Headaches/Migraines	YES / NO
Diabetes	YES / NO	Heart Condition	YES / NO
Blackouts or fainting fits	YES / NO	Digestive Problems	YES / NO
Do they get travelsick?	YES / NO		

(If yes to any of the above, please give details here)

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17. **Nursery children only**
 Do they need help to go to the lavatory? YES / NO
 Do they have any speech and language problems or problems communicating? YES / NO

(If yes to any of the above, or you have further information about your nursery child, please give details here)

18. What immunisations has he/she had?

All pupils should have had:	Date of Primary Course	Date of Boosters
Diphtheria/...../...../...../.....
Tetanus/...../...../...../.....
Poliomyelitis/...../...../...../.....
Whooping Cough (pertussis)/...../.....	N/A
Mumps/Measles/Rubella (MMR)/...../.....	N/A
Measles/...../.....	N/A
HIB/...../.....	N/A

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19. Can they swim 50m? YES / NO
 Can they go swimming in a public swimming pool? YES / NO
 (If no to any of the above, please give details of their ability)

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20. Are there any occasions in which in an emergency you would **not** wish the participant to receive emergency attention? YES / NO (If yes please explain here)

ADMINISTERING OF MEDICINES POLICY

- All medicines are kept in a locked cupboard in the office for day pupils. Boarders medicines are kept in sick bay in the Boarding House and are administered by the Boarding staff out of working hours. All treatments are recorded at the time or as soon as is practicable.
- Asthma reliever inhalers are kept either with the child or in the child's classroom with immediate access. An additional "spare" inhaler may be left at school.
- If your child carries an Epipen, please complete the Allergies Alert sheet available from the office. Pupils that are prescribed Epipens (or equivalent) keep their pens with them in their classroom and a spare is kept in the office.
- We request that any prescribed medicine which must be administered during the day is handed to the office staff along with completion of the consent form. These medicines must be in the original packaging with the pharmacy label present.

- The following homely/household medicines are kept in school and may be administrated with your consent. We would be grateful if you could complete the attached consent form.
 - Paracetamol suspension
 - Cough remedy
 - Piriton suspension
 - Anthisan cream/Waspeze (insect bites, nettle rash)
 - E45/ Calamine cream
 - Vaseline
 - Milk of Magnesia

Please note we do not use Ibruprofen per Dfes guidelines.

CONSENT FOR ADMINISTRATION OF MEDICINES AND FIRST AID AT BOUNDARY OAK SCHOOL:

I/we have read the medicines policy and consent to (Print name)having the following medication if needed.

Paracetamol suspension	YES	NO.....
Piriton	YES	NO.....
Miscellaneous items as listed in the policy	YES	NO.....

I/We also consent to any first aid treatment and administering of medicines above for my/our child in school. I agree to update the school of any changes in my child's medical history and contact details for me/ourselves ASAP.

Signature

NOTE: The medical profession takes the view that Parents Consent for medical treatment cannot be delegated. Thus consent forms have no legal status and a doctor will insist on the consent of a parent for treatment. However, it can be a comfort to have general consent in advance from parents and to have an adult who is able to complete some of the forms required by the Medical Authorities.

Should the occasion arise that your son or daughter may need emergency medical treatment and it proves impossible to contact you immediately, it is required by the D.S.S. that we have your written permission to act in loco parentis should we feel that emergency treatment be necessary. The most usual course of action would be to take your son/daughter to a local Emergency Hospital.

I give my permission for Boundary Oak School to act in loco parentis for emergency treatment for my son/daughter including a transfer to hospital. I understand that I will be contacted ASAP.

Name in full.....Signature

Date