



PUPIL MEDICAL INFORMATION FORM

(It is essential all fields are completed)

All information given will be treated in the strictest confidence, although relevant information will be passed onto teaching and sports staff on a need to know basis. *If you have any concerns regarding your child's medical and health issues, please contact the School Nurse on 020 8783 4031 or via email nurse@hamptonschool.org.uk*

Boy's surname:

Boy's forename(s):

Date of birth (day/month/year):

Address:

Contact Details

Please tick your preferred contact number (please tick <u>one</u> number only)			√
Home	Home telephone number		
Mother	Full Name		
	Work telephone number		
	Mobile telephone number		
Father	Full Name		
	Work telephone number		
	Mobile telephone number		
Alternative daytime contact (in case of emergency)	Full Name		
	Telephone number		
	Relationship to boy		

GP's Details (please note it is essential that this section is fully completed)

Name of GP	
Name of Surgery	
Address Line 1	
Address Line 2	
Town	
Postcode	
Telephone number	

Medical History

Does your son currently suffer from, or has he ever suffered from, any of the following? *If you answer yes to any question, please give details in the space provided on page 4.*

	Yes	No
Serious allergy	<input type="checkbox"/>	<input type="checkbox"/>
Psychological problems/mental health issues	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Does your son use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Fits/convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Deafness/ear problems	<input type="checkbox"/>	<input type="checkbox"/>
Visual impairment/difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Colour blindness	<input type="checkbox"/>	<input type="checkbox"/>
Speech difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in any limbs	<input type="checkbox"/>	<input type="checkbox"/>
Learning difficulties	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please give details on page 4</i>		
Dietary requirements	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please give details below</i>		

Please list any operation your son has undergone, indicating the type of operation and when it occurred:

Immunisations

Has your son had the following immunisations? Please tick the appropriate box.

Disease	Age (months) 2	Age (months) 3	Age (months) 4	Age (months) 12-15	Age (years) 3-5	Age (years) 13-15
Diphtheria						
Tetanus						
Whooping cough						
Poliomyelitis						
Hib vaccines						
Meningitis C						
MMR						

Medical Conditions

Does your son suffer from any medical condition or mental health issues? Yes/No

Condition/Issues

Please give details of any medication your son takes, prescription or non-prescription

Does your son have any requirements pertaining to their medical condition that need to be met during the School day? ***Please do not hesitate in contacting the School Nurse to discuss any concern you may have regarding your son's medical and health issues.***

Administration of Medicines

It is School policy that pupils must not carry medication on their person, with the exception of inhalers, auto-injectors for allergies and insulin pens. All medication must be handed to the School Nurse with written instructions regarding dose and administration.

Does your son need to take any medication during the School day? Yes/No

If yes, please give details

The School Nurse, after assessing your son, may deem it appropriate to administer over-the-counter medicines, but would only do so with your permission. Please tick the boxes below and sign the form giving the School Nurse permission to administer these medicines to your son if required.

	Please tick for permission
Paracetamol - analgesia/antipyretic	
Ibuprofen - analgesia/anti-inflammatory	
Cetirizine Hydrochloride 10mg - antihistamine/hayfever symptoms	
Anthisan - antihistamine cream/insect bites	
Throat lozenges. Simple linctus - cough syrup	

Parent's signature

Date

Learning Difficulties

Please give details

Please use the space below to provide any additional information