Medical Questionnaire

Student's Last Name:	Student's First Name:	Date of Birth:
……	…….....	……...

Has your child had any of the following:	Yes	No
Asthma or Bronchitis	☐	☐
Heart Condition	☐	☐
Fits, fainting or blackouts	☐	☐
Severe headaches	☐	☐
Diabetes	☐	☐
Any known allergies	☐	☐
Other illness or disability	☐	☐
Any recent contact with contagious diseases and infections	☐	☐

If the answer to any of these questions is YES, please give further details:

Immunisation Status

Has your child received vaccination against Tetanus in the last ten years?

Yes ☐ No ☐ Don't know ☐

Medical Treatment

Is your child receiving medical treatment of any kind from either your family Doctor or Hospital?

Yes ☐ No ☐

Has your child been given specific medical advice to follow in emergencies?

Yes ☐ No ☐

If the answer to either of these questions is YES, please give the details including dosage of any medicines/tablets:

If your child has been provided with a treatment/care plan please provide the school with a copy when the medication is sent into school.

I agree to my son / daughter receiving emergency medical treatment which might include the use of anaesthetic and blood transfusions as considered necessary by the medical authorities present.

Signature of Parent/Carer: ……

Date: ……

Please note we can only store Paracetamol and prescribed medication by a GP for your child at school. Medication should be provided in its original packaging. If your child requires medication at school, please complete the form overleaf and return it to school.

Student Medication

Please complete and return this form to Student Services if you require medication to be held in the Student Office for your child. Please complete all sections.

Student's Last Name:	**First Name:**	**Year/Tutor Group:**	**Date of Birth:**

Home Address:

Condition or Illness:	**Please give details:**

Name of Medication:	**Dose:**	**Frequency/ Times:**	**Completion date of course (if known):**	**Expiry date of medicine:**

Special instructions:

Allergies:

Other prescribed medicines child takes at home:

Please ✓ the appropriate box

☐ My child will be responsible for self-administration of the medication detailed above.

☐ I agree to members of staff administering medication/providing treatment to my child as detailed above.

Parent/Carer Contact Nos:	**Name:** **Tel No.**	**Name:** **Tel No.**

GP Name:	**Address:**	**Tel No.**

Please read the following statement and sign and date.

- I agree to members of staff administering medication/providing treatment to my child as detailed.
- I agree to update information about my child's medical needs held by Oakwood school.
- I will ensure that the medication held by Oakwood school has not exceeded its expiry date.

Signed …….. **Date** …….

Please note we can only hold Paracetamol and prescribed medication for your child. Medication should be provided in its original packaging.