Confidential Medical Questionnaire

Family Name (CAPITAL LETTERS)

First Name

Date of Birth

Class / Tutor Group

Emergency Contact Numbers

1)

2)

Name, address and telephone contact details of your child's doctor:

General Health

Has your child ever required treatment for any of the following conditions?

	Yes	No		Yes	No
Asthma			Hay fever		
Bone/joint disease			Hepatitis		
Convulsions/epilepsy			Heart condition		
Ear/nose/throat problems			Menstrual problems		
Endocrine disorders, e.g. diabetes, thyroid			Migraine/headaches		
Eczema/skin condition			Psychological problems		

If you have answered YES for any of the above, please give dates and details:

Is s/he still receiving treatment? ☐ YES ☐ NO

If YES, please give details of treatment:

Please give dates and details of any other illness, operations, recent accidents or hospital investigations and any treatment still required:

This document will be stored confidentially by the School Doctor

Confidential Medical Questionnaire

Allergy

Does your child have any known allergies? ☐ YES ☐ NO

If YES, please give details including symptoms experienced and treatment required.

Diet

Does your child have any known allergies? ☐ YES ☐ NO

If YES, please give details including symptoms experienced and treatment required.

Hearing

Date of last hearing test

Does you child have any problems with hearing? ☐ YES ☐ NO

If YES, please give details:

Vision

Date of last eye sight test

Does your child wear reading glasses? ☐ YES ☐ NO

Does your child wear contact lenses? ☐ YES ☐ NO

Is s/he colour blind? ☐ YES ☐ NO

Family History

Is there any history of physical or mental illness in the family which might affect the student's health?

☐ YES ☐ NO

If YES, please give details

Is there any other feature of your child's physical or mental health which you feel the School Doctor should be aware of, or which you would like to discuss with the Doctor? ☐ YES ☐ NO

If YES, please give details

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Confidential Medical Questionnaire

Sports & Activities

Is there any reason why your child should not take part in all the normal school sport and activities?
YES ☐ NO ☐ If YES, please include details

Medication

Is your child currently taking any medication? ☐ YES ☐ NO
If YES, please give details, including dosage

Does your child require particular medication to take in an emergency?
e.g. Epi-pen ☐ YES ☐ NO
If YES, please give details:

Consent

I give my permission to the School Doctor or other qualified personnel to administer routine first aid and non-prescription, over the counter medicines to my child when necessary, e.g. paracetamol, sticking plaster, antacid.

Parent's Signature **Date**

Certain medical conditions may require information to be given to selected members of staff.
Please give your consent below:

I consent to essential medical information being given to selected staff.

Parent's Signature **Date**

I agree to the School Doctor or other qualified personnel approving medical treatment for my child as is deemed necessary in an emergency.

Parent's Signature **Date**

I undertake to supply the school with any necessary prescription medication which my child may require and to keep the school updated with any changes in my child's condition.

Parent's Signature **Date**

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