

HEALTH CENTRE

Please complete the attached medical form in full and return to;

The Health Centre

Whitefield

18 Park Crescent

Abingdon

OX14 1DD

Email: [*health.centre@abingdon.org.uk*](mailto:health.centre@abingdon.org.uk)

A hard copy is preferred.

**PLEASE USE THE FOLLOWING NOTES TO ASSIST WITH THE COMPLETION OF THE MEDICAL FORM.**

1. **IMMUNISATIONS:** Please fill in the dates given. This information can be found in your sons Red Book or your GP surgery should be able to provide you with an up to date print out.

**National Child Health Program:** It is the school policy to immunise children within the National child health program. The Diphtheria, Tetanus & Polio combined vaccine is given during year 3. Any identification of an incomplete course of MMR or Meningitis C will be offered as a catch up.

Parents will receive a consent form, which we require completed and returned promptly to ensure arrangements can be made, for the School Health Nurses from Oxford Health NHS Foundation Trust to provide this service.

Information regarding immunisations can be found on: [*www.immunisation.nhs.uk*](http://www.immunisation.nhs.uk)

1. **PAST MEDICAL HISTORY:** Please contact the Health Centre if you would like to discuss,

**in** **confidence**, any concerns regarding your son’s health, including any chronic conditions.

Please keep the School Health Centre informed of any new medical conditions and updates, or if previous conditions have resolved or are no longer relevant.

**3. MEDICATION:** We can hold a spare Ventolin inhaler for your son at the Health Centre or any medication, which may be required in an emergency. All such should be clearly labelled with your son’s name.

Please note for those boys who carry an **EPIPEN**, that they should have one on their person at all times and a spare is to be held at the Health Centre.

Please note that it is your responsibility to ensure that all such medication is clearly labelled and in date.

We will inform you of any treatment/medication administered to your son either by phone or email if appropriate.

1. **FOOD ALLERGIES/INTOLERANCE:** If your son requires a special diet please provide written details from your GP before the start of term.



MEDICAL FORM – DAY BOY

CONFIDENTIAL

The information on this form will remain **confidential.**

Information relating to special health care needs, relevant history and parental consents will be shared with the House Master, Tutor, House Matron and other staff as appropriate.

Please complete and return preferably by post to: The Health Centre, Whitefield,

18 Park Crescent, Abingdon, OX14 1DD. Email: [*health.centre@abingdon.org.uk*](mailto:health.centre@abingdon.org.uk)

*FAILURE TO RETURN THIS FORM MAY DELAY THE ADMISSION OF YOUR SON*

**PUPIL’S FIRST NAME…………………………………………………..**

**SURNAME………………………………………………………………..**

**DATE OF BIRTH………………………………………………………...**

**1: IMMUNISATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| **WHEN IMMUNISATION IS DUE** | **WHAT VACCINE** | **HOW IT IS GIVEN** | **DATE RECEIVED** |
| **2 months/8 weeks** | Diphtheria, Tetanus, Pertussis, Polio and Hib (DTaP/IPV/Hib) | 1 injection |  |
| **2 months/8 weeks** | Pneumococcal PCV | 1 injection |  |
| **3 months/12 weeks** | Diphtheria, Tetanus, Pertussis, Polio and Hib (DTaP/IPV/Hib | 1 injection |  |
| **3 months/12 weeks** | Meningitis C | 1 injection |  |
| **4 months/16 weeks** | Diphtheria, Tetanus, Pertussis, Polio and Hib (DTaP/IPV/Hib | 1 injection |  |
| **4 months/16 weeks** | Pneumococcal PCV (2nd dose) | 1 injection |  |
| **12 – 13 months** | Hib/Meningitis C | 1 injection |  |
| **12 – 13 months** | Measles, Mumps, Rubella (MMR) (1st dose) | 1 injection |  |
| **12 – 13 months** | Pneumococcal PCV (3rd dose) | 1 injection |  |
| **3 years 4 months – 5 years** | Diphtheria, Tetanus, Pertussis, Polio (DTaP/IPV or dTaP/IPV) | 1 injection |  |
| **3 years 4 months – 5 years** | Measles, Mumps, Rubella (MMR) (2nd dose) | 1 injection |  |

**2: PAST MEDICAL HISTORY**

**Has your son had any of the following? (Please give dates, details and any on going treatment below).**

1. Any serious illness Yes/No
2. Any surgical operations Yes/No
3. Any heart or lung disease including congenital abnormalities Yes/No
4. Any ear disease Yes/No
5. Any fainting attacks, fits or convulsions Yes/No
6. Any kidney, bladder or urinary disorder Yes/No
7. Recurrent sore throats Yes/No
8. Any bone or joint problems Yes/No
9. Any serious head or neck injury Yes/No
10. Any mental or emotional illness Yes/No
11. Any tropical disease Yes/No
12. Malaria Yes/No
13. Any other illness or disorder Yes/No

*If you have answered yes to any of the questions above please give details*

*………………………………………………………………………………………………………*

*………………………………………………………………………………………………………*

**3: Current Health**

**Does your son have (please provide details of current treatment):**

a) Asthma Yes/No …………………………………………………

b) Hay fever Yes/No……………………………………………........

c) Eczema Yes/No………………………………………………….

**3: Current Health (continued)**

d) Diabetes Yes/No………………………………………………….

e) Epilepsy Yes/No………………………………………………….

f) Is he allergic to anything including any medicines? Yes/No…………

……………………………………………………………………………………

……………………………………………………………………………………

g) Dose your son carry an EPIPEN for Anaphylaxis Yes/No…………

……………………………………………………………………………………

……………………………………………………………………………………

h) Does your son have any food allergies Yes/No…………

…………………………………………………………………………………...

**4: First Aid**

In the event of **minor** illness or injury occurring at school, do you authorise the Senior School Nurse or her deputy to administer First Aid and any of the following medication as appropriate to your son?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  | **YES** | **NO** |
| **\*Paracetamol** |  |  | **Indigestion remedies** (eg Gaviscon) |  |  |
| **Ibuprofen** |  |  | **\*Skin preparations** for treating cuts, grazes, burns bites and stings**.** |  |  |
| **\*Lozengers** (coughs, sore throat etc.) |  |  | **Chlorphenamine** |  |  |
| **\*Cetirizine** |  |  | **Salbutamol for Asthmatics** |  |  |

**Signature** of consent to the above……………………………………..

**First Aid On School Trips**

Do you consent to the administration of first aid and the above \*medication by teaching staff?

**Signature**…………………………………………………………………………

**In Loco Parentis**

In the event of serious illness or injury where delay might prove dangerous, do you authorise the Head or her representative to give permission on your behalf for any treatment, including anaesthetic or operation? *Every effort will be made to contact you first.*

**YES/NO** If no, please state reason……………………………………………………………..

……………………………………………………………………………...........................................

……………………………………………………………………………………………………………

**Signature**…………………………………………………………………………..

**Other Information**

Is there any other information the staff in the Health Centre should be aware of? E.g. death of a parent, sibling or close family member, separation, divorce or other social circumstances.

**YES/NO**

If yes please give details……………………………………………………………………………….

……………………………………………………………………………...........................................

……………………………………………………………………………………………………………

**Does your son have medical insurance?**  YES / NO

If yes, please give details of insurance company and policy number: ……………………………………

…………………………………………………………………………………………….……………………….

Please give the name, address and telephone number of your family doctor below:

Family Doctor Name:……………………………………………………………………………………...

Address: …………………………………………………………………………………………………....

Telephone No: ……………………………………………………………………………………………..

Please provide us with the following contact details:

**Primary Contact:**

Name…………………………………………. Relationship to child………………………..

Address……………………………………….. Home Tel:…………………………………

……………………………………………….. Mobile Tel:………………………………...

……………………………………………….. Work Tel:…………………………………

**Other emergency contact:**

Name:…………………………………………. Tel:………………………………………..

Relationship to child……………………………. Alternate Tel:………………………………

# I / we accept the above condition of entry to Abingdon School

Signature(s):…………………………………. ………………………………………………

Print Name(s):………………………………... ………………………………………………

Date……………………………………………. ………………………………………………

**Mrs Annette Hack, Senior Nurse**

**01235 849059** [*health.centre@abingdon.org.uk*](mailto:health.centre@abingdon.org.uk) *Updated March 2015*