



CONFIDENTIAL
WEST BUCKLAND SCHOOL HEALTH RECORD 2023-2024

Pupil's Surname Forenames

Pupil's Date of Birth

Name of parent/guardian completing this form

Please fill all sections in with as much details as possible in order for us to have an accurate record of your child's health.

Participation in all off-site activities is dependent on the return of this form. It should be completed by a parent or guardian of the pupil, and returned to the School Office as soon as possible.

All sections of this form should be completed and the information provided will be recorded on the school's database. It is a parental responsibility to inform the school's Medical Centre of any changes to the medical information provided and to advise the School Office of any changes to contact details.

The details you provide will be kept secure but available to staff on all off-site activities in case medical treatment is necessary. If there are any queries on medical matters contained within this form, please contact Sister (Mrs Kate Pouncey) on 01598 760143. Alternatively you may contact the Deputy Head (Mr David Hymer) on 01598 760128 or dmh@westbuckland.devon.sch.uk.

Home Address

Home Phone Number

Parents' Work Numbers

.....

Mobile Emergency Numbers

.....

Email address

Date entered the UK (if from overseas)

Further contact name(s) and telephone numbers in case of emergency

Name Address

Relationship to child

Phone Number

Name Address

Relationship to child

Phone Number

Family Doctor

If your child is or ever has been registered with a GP surgery in the UK please give details...

Doctor's Name Phone Number

Name of Surgery

Childs NHS number.....

Where necessary either at school or on an off-site activity, I agree to my son/daughter receiving first aid as necessary. I understand that in an emergency, every effort will be made to obtain my consent to an operation and/or administration of an anaesthetic. If this proves impossible I agree to my son/daughter receiving any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

Signature of parent/guardian

Please delete any medications in the table below which you would be unhappy for Sister (and houseparents, for boarders) to administer for illnesses such as sore throat, cough, asthma, headache, migraine, period pains, hay fever or sports injuries:

- | | |
|----------------|------------------------------|
| Paracetamol | Ibuprofen |
| Peptac | Pseudoephedrine |
| Simple Linctus | Asthma inhalers or nebuliser |
| Cetirizine | Cinnarizine |

Signature of parent/guardian

On residential offsite activities a separate medical and consent form is issued, but for sports fixtures and other day trips there is occasional demand for basic pain relief. **Please delete any medications in the table below which you would be unhappy** to be administered by teachers supervising off-site activity. (The teachers will have received basic training from the school nurse.)

- | | |
|----------------|------------------------------|
| Paracetamol | Ibuprofen |
| Peptac | Pseudoephedrine |
| Simple Linctus | Asthma inhalers or nebuliser |
| Cetirizine | Cinnarizine |
| Suntan Lotion | |

For all children who suffer from asthma:

Please sign to agree you are happy for teachers to administer an asthma inhaler in case of emergency, (these are contained in all first aid bags)

Signature of parent/guardian

My child and I consent to teachers and houseparents being informed of relevant major medical problems, (eg asthma, diabetes, epilepsy, allergies).

Signature of parent/guardian

For Boarders Only:

I agree to the prescription and administration of medication to my child if deemed necessary by the School Doctor, on the understanding that Sister will endeavour to keep me informed of any illness or treatment.

Signature of parent/guardian

I understand that an additional charge may be added to the school bill to cover staff and travel costs in the case of transporting a pupil to a medical or dental appointment.

Signature of parent/guardian

MEDICAL INFORMATION

Please complete the following details to help us provide the best medical care for your child. Please list details separately if necessary. If any of these details change, you should inform the school immediately.

All pupils:

Medication: *Please give details of any prescribed medicines (including dose and frequency)*

.....
.....
.....

Please state if your child have had a positive Covid -19 test Yes / No

Was it a blood or swab test? Blood / Swab

Family History: Is there any family history of illness which might have a bearing on his/her health, including psychiatric illness, high blood pressure, heart disease or diabetes?

.....
.....

Sport: Is s/he fit in all respects to participate in the usual school sporting activities? **Yes /No** If no, please give details

.....
.....

Diet: Please give details of any special dietary requirements

.....
.....

All Pupils:

Condition	Yes	No	Date and Details
Lung problems (e.g, Asthma)			
Diabetes or thyroid problems			
Fits or epilepsy			
Headaches or migraine			
Ear, nose and throat problems (including hayfever, ear infections or hearing problems)			
Eye problems			
Does s/he wear spectacles?			Date of last eye test:
Allergy to drugs or food			
Travel sickness			
Any other medical condition			

All remaining questions are for Boarders Only:

Infections including:			
• Chicken pox			
• Meningitis			
• Tuberculosis			
• Contact with active pulmonary TB			
• Other major infections			
Heart problems			
Gastrointestinal problems			
Urinary problems			
Gynaecological/period problems			
Skin conditions			
Dental problems			Date of last dental check:
Arthritis/joint problems			
Fractures			
Surgical operations			

Has s/he ever had a chest X-ray?

(Please give date and result).....

Has s/he lived abroad? (Please state country)

Immunisations

Please give dates of ALL immunisations (please attach record if possible). The school Doctor will review your child immunisation record and may recommend some further immunisations based on the UK childhood immunisation schedule which can vary slightly from other countries. Your child will be informed if any further immunisations are recommended.

Immunisation	Date				
Tetanus					
Diphtheria					
Polio					
Pertussis (Whooping Cough)					
Haemophilus Influenza B (Hib)					
Hepatitis B (HepB)					
Meningitis B (MenB)					
Pneumococcal infection					
Meningitis C					
Measles/Mumps/Rubella (MMR)					
Human Papilloma Virus (HPV)					
Meningitis A,C,W,Y (Men ACWY)					
BCG (TB) if from high risk country					
Covid 19					
Other (please give details of name and dates)					

We would like your child to be vaccinated in line with the UK National Immunisation Schedule. Do you consent to the following vaccinations being updated if necessary? (Please delete if you do not give consent)

Tetanus, Diphtheria, Polio

Measles, Mumps & Rubella (MMR)

Men ACWY

HPV

Signature of parent/guardian