



WEST HILL PARK

Pupil Medical Questionnaire

Please answer the following questions relating to the health of your child as fully as possible. All questionnaires are kept confidential.

Full Pupil Name:		Date of birth:	
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GP Name and Address:	
Telephone Number:	

NHS Number:	
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Please tick your answers as appropriate

Has your child been immunised against:	Yes	No	Has your child had:	Yes	No
Diphtheria, Tetanus & Polio			Influenza		
Mumps, Measles & Rubella (MMR)			Measles		
Whooping Cough			Mumps		
Hib. Meningitis			Chicken Pox		
Meningitis C			German Measles		
Pneumococcal			Scarlet Fever		
Covid					



Does your child have any specific dietary requirements?	If yes, please give details:	Yes	No
Does your child have any allergies?	If yes, please give details:	Yes	No
Does your child have asthma?	If yes, please give details:	Yes	No
Does your child have Hayfever?	If yes, please give details:	Yes	No
Does your child have any other medical conditions?	If yes, please give details:	Yes	No
Does your child take any regular medications which need to be given during the school day?	If yes, please give details:	Yes	No
Are there any family medical conditions or circumstances that would be of value to be known by the medical staff at school?	If yes, please give details:	Yes	No
Has your child ever been treated in hospital, either as an Out-Patient or In-Patient in the last 12 months?	If yes, please give details:	Yes	No
Does your child have hearing problems?	If yes, please give details:	Yes	No
Does your child wear glasses?	If yes, please give details:	Yes	No
Does your child have an orthodontic appliance?	If yes, please give details:	Yes	No
Does your child suffer from travel sickness?	If yes, please give details and provide suitable medication:	Yes	No
Are there any concerns about your child's health and well-being which you think might be helpful for us to know?	If yes, please give details:	Yes	No

First Aid and Medical Emergency Consent

In order for your child to receive First Aid treatment whilst attending West Hill Park School, or an offsite activity under the supervision of West Hill Park staff we need your written consent.

All first aid treatment is given by a qualified member of staff.

In the unlikely event of the school being unable to contact you in medical emergency we require your permission for the Headmaster or a delegated member of staff to act in 'Loco Parentis' and to be able to consent to avoid any delay in treatment as recommended by a medical professional.

I give consent for my child to receive First Aid treatment in the event of a minor injury or illness. If an emergency occurs and when all reasonable efforts to contact me have failed, I authorise the school to assume 'delegated parental responsibility'. I give permission for x-rays, medical/dental treatment, blood transfusions, hospitalisation and operation to be performed on my child if the school is so advised by appropriately qualified medical/dental personnel.

Parent/Guardian (s): Signature:	Date:
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Sharing Information

At times, it may be appropriate to share medical information given on this form with relevant staff at West Hill Park School. It is in your child's interest that you should give permission to share information, which is carried out at the discretion of the medical staff or other appropriate members of staff.

I give consent for my child's medical information to be shared with relevant staff at West Hill Park School.

Parent/Guardian(s): Signature:	Date:
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Important:

You are advised that West Hill Park School cannot be held responsible for errors or omissions made within this document. West Hill Park School claims the right to withdraw a child from school if withheld information comes to light which has a negative bearing on the child's position in school.

Data Protection Information from this form will be processed in accordance with the General Data Protection Regulation 2018. By ticking here ___ you expressly consent to this data being held and processed by West Hill Park School, in accordance with the Act. Our privacy policy is available from our website www.westhillpark.com

Pupil Medical Consent Form

At times it is necessary for the surgery to administer over the counter medications for treatment. Due to regulatory requirements, we can only administer non-prescription medicines if we are in receipt of a signed permission slip from parents.

Full Pupil Name:		Date of Birth:	
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Allergies:	
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Please circle your answers as appropriate

Paracetamol	Yes	No	HypoAllergenic Dressings	Yes	No
Ibuprofen	Yes	No	Oral Antihistamine	Yes	No
Antiseptic Cream	Yes	No	Topical Antihistamine	Yes	No
E45 Itch Relief	Yes	No	Halls sugar free lozenges	Yes	No

NB No pupil will be given any time framed medication prior to 1300

I hereby consent to the above medications, topical creams and dressings to be given and applied as deemed necessary by delegated staff.			
Parent/ Guardian Signature:		Date:	