Coopersale Hall School

Pupil Health Questionnaire and Consent Form

PLEASE COMPLETE ALL QUESTIONS AND PRINT ALL DETAILS.

The School requires you to complete all sections of this form as fully as possible. The information provided by you in this form will be treated in confidence and will help us to care for your child while he/she is a pupil at the School.

For more information about how the School may use your and your child's information contained in this form, please see our Privacy Notice that is published on the School website: www.oaktreeschools.co.uk/data-protection.

Pupil's Full Name			
Date of Birth		Sex	

Home Address		Home Telephone No	
Mother's Mobile No		Mother's Work No	
Father's Mobile No		Father's Work No	
Emergency Contact(s) Name and Tel No (other than above)			

G.P's Name			
G.P's Address		G.P's Telephone No	

ETHNIC ORIGIN - PLEASE TICK ONE BOX ONLY			
White		**Black or Black British**	
White		Caribbean	
Irish		African	
Any other White Background		Any other Black Background	
Asian or Asian British		**Mixed**	
Indian		White and Black Caribbean	
Pakistani		White and Black African	
Bangladeshi		White and Asian	
Any other Asian Background		Any other Mixed Background	
Chinese		**Other/Unknown**	
Hong Kong Chinese		Any other Ethnic Background	
Any Other Chinese Background		Ethnic Background Unknown	
I do not wish an ethnic background category to be recorded			

Please give full details in the space provided and use additional sheets where necessary

HEALTH/SPECIAL NEEDS			
	Yes	No	Details
Is your child in good health?			
Is he/she attending hospital for any treatment?			
Has he/she any skin troubles such as eczema?			
Does he/she suffer from asthma/bronchitis?			
Does he/she get severe headaches/migraines?			
Does he/she suffer from any of the following? • Heart problems • Kidney disease • Epilepsy, fainting or dizziness • Diabetes – type 1 or 2			
Does he/she have any hearing problems?			
Does he/she have any eye problems, including colour blindness or needing glasses/lenses?			
Does he/she have any disabilities?			

INFECTIOUS CONDITIONS - please indicate by ticking either Yes or No for each condition			
	Yes	No	Approximate date of infection
Mumps			
Rubella			
Chicken pox			
Measles			
Glandular fever			
Rheumatic fever			
If you answered 'Yes' to any of the above, please provide details below:			
Has your child been in contact with anyone with an infectious or contagious disease? (if 'Yes', please provide details below)			

ALLERGIES - if you indicate 'Yes' to any of these questions you must complete a School Health Care Plan			
	Yes	No	Details
Is your child allergic to any foods such as nuts?			
Does he/she suffer from hay-fever?			
Does he/she suffer from allergic reactions to bee or wasp stings?			
Does he/she suffer from an allergic reaction to any drugs or medicines such as Penicillin?			
Does he/she suffer with any allergic reactions that require the administration of an EPIPEN or other auto-injector?			
Does he/she suffer from an allergic reaction to any animals?			

IMMUNISATION - please indicate whether your child has received the following vaccinations				
Age normally given	**Immunisation**	**Site**	**Yes/No**	**Date received**
8 weeks old	Diptheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenza* type b (Hib) – Dose 1	Thigh		
8 weeks old	Pneumococcal – Dose 1	Thigh		
8 weeks old	Meningococcal group B (MenB) – Dose 1	Left thigh		
8 weeks old	Rotavirus gastroenteritis	By mouth		
12 weeks old	Diptheria, tetanus, pertussis, polio and Hib – Dose 2	Thigh		
12 weeks old	Meningococcal group C	Thigh		
12 weeks old	Rotavirus	By mouth		
16 weeks old	Diptheria, tetanus, pertussis, polio and Hib – Dose 3	Thigh		
16 weeks old	Pneumococcal – Dose 2	Thigh		
16 weeks old	Meningococcal group B (MenB) – Dose 2	Left thigh		
1 year old	Hib and MenC	Upper arm/thigh		
1 year old	Pneumococcal – Dose 3	Upper arm/thigh		
1 year old	Measles, Mumps and Rubella (MMR) – Dose 1	Upper arm/thigh		
1 year old	MenB (booster)	Left thigh		
2 to 6 years old	Influenza	Both nostrils		
3 years old	Diptheria, tetanus, pertussis and polio	Upper arm		
3 years old	Measles, Mumps and Rubella (MMR) – Dose 2	Upper arm		
Optional	Chicken Pox			
Optional	BCG (Tuberculosis)			
Optional	Influenza			

TRAVEL VACCINATIONS - please indicate whether your child has received the following vaccinations			
Immunisation	**Site**	**Yes/No**	**Date received**
Typhoid			
Cholera			
Yellow Fever			
Meningitis (meningococcal types A and C)			
Hepatitis A			
Hepatitis B			
Japanese encephalitis			
Tick-borne encephalitis			
Rabies			
Other (please provide details in the box below)			

MEDICATION - if you indicate 'Yes' to any of these questions you must complete a School Health Care Plan			
	Yes	No	Details
Does your child require any prescribed medication on a daily basis?			
Can this medication be self-administered?			

MEDICATION AND TREATMENT - please provide the details of all medication/treatment below			
Name	**Reason**	**Dosage (if applicable)**	**Frequency**

Please provide details below of any condition which may prevent your child from taking a full part in the School's academic and games or sports curriculum, and outdoor activities.

DIETARY NEEDS			
	Yes	No	Details
Does your child have any special dietary needs, such as no eggs, dairy products, vegetarian etc?			

SPECIAL NEEDS - any specialist reports must be attached			
	Yes	No	Details
Has your child ever experienced any cognition and/or learning (general or specific) difficulties?			
Has your child ever experienced any behavioural, emotional and/or social difficulties?			
Has your child ever experienced any communication and/or interaction difficulties (eg language or autistic spectrum disorders)?			
Has your child ever experienced any mental health conditions?			
Has your child ever experienced any physical difficulties?			
Have you ever sought any specialist advice with any difficulties, eg an Educational Psychologist?			
Do you have any reports on your child that we need to see, eg a dyslexia report?			

DECLARATION

Minor illnesses and injuries are treated at school and recorded. Parents are informed as soon as possible if it is necessary for children to go home or go to hospital. All accidents are recorded in the Accident Book, which is monitored regularly by the Health and Safety Officer.

Children who are unwell must be kept at home. All advice is in the school's 'Sickness and Medication' Policy Part 1 and 2 available to download from the school's website.

The school will only take responsibility for administering any medication on completion of the 'Request to Administer Medication Form' by the parent(s) of the child. This form is available from the School Office.

- **I/WE** have provided full and complete information about my/our child in this Medical Information Form.
- **I/WE** agree to inform the School in the event that my/our child's health or needs change.
- **I/WE** agree to inform the School of any medication or treatment my child is receiving as I understand that appropriately qualified School staff may administer medication or need to refer on to Medical, Dental and Optical specialists as required.
- **I/WE DECLARE** the above statements to be correct on behalf of my/our child.
- **I/WE GIVE MY/OUR CONSENT,** if I/we have indicated 'Yes' to any medical condition/dietary requirements, for small photographs of my/our child to be appropriately displayed to assist First Aiders and Lunchtime Staff.

MEDICAL CONSENT

- **First Aid:** I/We consent to appropriately trained and qualified members of the school staff to administer first aid to my/our child where appropriate.
- **Medical Treatment:** I/We hereby give my consent for the School to act on my/our behalf as necessary for my child's welfare if he/she requires a medical examination, medical testing or minor treatment such as attendance at a local GP, Doctor or Optician.
- **Emergency Medical treatment:** I/We give my/our consent for the Head to act on our behalf to authorise emergency medical treatment as necessary for my child's welfare in the event I/we cannot be contacted in time.

If there is any medication or any remedies you would prefer your child not to receive, please indicate these below

The signature of **BOTH** parents or guardians is required.

	First Signatory	**Second Signatory**
Signature		
Title (e.g. Mr, Mrs, Ms)		
Name in full (please include all names)		
Relationship to child		
Date		