



STUDENT MEDICAL RECORD

STUDENT NAME:	DATE OF BIRTH (DD/MM/YY):	GENDER: M <input type="checkbox"/> F <input type="checkbox"/>	GRADE:
MOTHER'S NAME:	FATHER'S NAME:		
TELEPHONE:	TELEPHONE:		

MEDICAL HISTORY *Does your child have any of the following conditions?* **MEDICATION PERMISSION** *Please tick.*

Asthma? Yes <input type="checkbox"/> No <input type="checkbox"/> Inhaler? Yes <input type="checkbox"/> No <input type="checkbox"/>	Paracetamol	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy? Yes <input type="checkbox"/> No <input type="checkbox"/>	Ibuprofen (as per GP only)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes? Yes <input type="checkbox"/> No <input type="checkbox"/>	Antihistamine Liquid/Tablets	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Cold/Flu Capsules (12yrs up)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Cough/Sore Throat Lozenge	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies?	Antiseptic Creams	Yes <input type="checkbox"/>	No <input type="checkbox"/>
To food? Yes <input type="checkbox"/> No <input type="checkbox"/>	Honey & Lemon Linctus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
To medicines? Yes <input type="checkbox"/> No <input type="checkbox"/>	Arnica Cream	Yes <input type="checkbox"/>	No <input type="checkbox"/>
To insect bites/stings? Yes <input type="checkbox"/> No <input type="checkbox"/>			
To plants/pollens? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Other? Yes <input type="checkbox"/> No <input type="checkbox"/>			

ANY OTHER MEDICAL CONDITION/DISABILITY =

For prescribed medications please complete the Medicine Authorisation Form.

Immunisation Record

Which country's immunisation schedule do you follow?

Does your child have any concerns related to:

IMMUNISATION	DATE #1	DATE #2	DATE #3	DATE #4	DATE #5	DATE #6
BCG						
Mantoux/PPD Test						
Diphtheria						
Pertussis						
Tetanus						
Oral/IPV Polio						
Measles						
Mumps						
Rubella						
HIB						
Hepatitis A						
Hepatitis B						
HPV/HPV4/HPV9						
Influenza						
MenB						
MenC/MenACWY						
PCV (Pneumococcal)						
Rotavirus						
Typhoid						
Varicella						
Yellow Fever						

- Development Yes No
- Growth Yes No
- Behaviour Yes No
- Co-ordination Yes No
- Speech Yes No
- Vision Yes No
- Colour Vision Yes No
- Hearing Yes No

Other information you feel may be of assistance to school.

Any other vaccines:

If you wish to discuss any concerns or queries please contact the School Nurse.

I hereby authorise the School Nurses, First-Aiders or authorised members of the school staff to administer basic first aid treatment to my child. In the event my child is injured or becomes seriously ill while under school supervision and immediate medical treatment is necessary to preserve my child's health, I authorise the staff member in charge to act on my behalf. I will inform the school as soon as possible of any changes in medical or other relevant circumstances. I certify that all information given on this form is complete and correct. **I also give permission for my information to be shared with the NHS for medical/immunisation purpose only (please circle) YES NO**

Signature of Parent/Guardian: _____ Print Name: _____ Date: _____