WARWICK INDEPENDENT SCHOOLS FOUNDATION

Medical Information and Consent Form

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

All information received on this form will be treated in confidence.

For more information about how the School may use your and your child's information contained in this form, please see our Pupil Privacy Notice-Key Information and our Parent Privacy Notice-Key Information which are enclosed with the letter of offer and published on the School website: http://www.kingshighwarwick.co.uk/School-Policies.

Child's details

Child's full name:	
Date of birth:	

Child's doctor's details

Name of child's doctor:	
Address of child's doctor:	
Telephone number for child's doctor:	

Eyesight and hearing

Does your child have an eyesight condition? (Please tick one box)	Yes		No	
Does your child have a hearing condition? (Please tick one box)	Yes		No	
If you have answered Yes to either question above, please provide details below:				
If your child takes any medication for an eyesight or hearing condition, please provide details in the Medication section in this form.				

Infectious conditions

Has your child had any of the following infectious conditions? (Please indicate by ticking either Yes or No for each condition)

Condition:	Yes	No	Approximate date of infection
Mumps			
Rubella			
Chicken pox			
Measles			
Glandular fever			
Rheumatic fever			
If you have 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 in the box below)			

Allergies

Does your child have any allergies?				
Hay fever	Yes		No	
Medicine (If Yes, please provide details in the box below)	Yes		No	
Animals (If Yes, please provide details in the box below)	Yes		No	
Foods (If Yes, please provide details in the box below)	Yes		No	
Other allergies (If Yes, please provide details in the box below)	Yes		No	

If your child takes any medication for an allergy, or carries an Epi-pen or other auto-injector, please provide details in the Medication and treatment section in this form.
If your child has special dietary requirements, please provide details in the box below:

Other conditions

Does your child have any of the following conditions?				
Asthma	Yes		No	
Diabetes - type 1	Yes		No	
Diabetes - type 2	Yes		No	
Epilepsy	Yes		No	
Mental Health condition(s) (If Yes, please provide details in the box below)	Yes		No	
Other condition(s) (If Yes, please provide details in the box below)	Yes		No	
If your child takes any medication or receives treatment for an above named condition, please provide details in the Medication and treatment section in this form.				

Immunisation

The following table lists the routine and optional vaccinations (including travel vaccinations) available for children in the United Kingdom.

Please provide date(s) of immunisation of your child where indicated or, if immunisation not carried out, please state.

Immunisation	Date(s) of Immunisation
Routine vaccinations	
5 in 1 vaccine (Diphtheria, Tetanus, whooping cough, polio, Hib)	
PCV (Pneumococcal jab)	
Rotavirus	
Men B (Meningococcal type B)	
Hib / Men C	
MMR (Measles, Mumps, Rubella)	
Children's flu vaccine	
4 in 1 Pre-school booster (Diphtheria, Tetanus, whooping cough, polio)	
HPV (girls only)	
3 in 1 teenage booster (Diphtheria, tetanus, polio)	
Meningitis (Meningococcal types A, C, W, Y)	
Optional vaccinations	
Chickenpox	
BCG (Tuberculosis)	
Influenza	

Hepatitis B	
Travel vaccinations	
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 and treatment

Name of medication/treatment	Reason for medication/treatment	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.

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 also 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 too Medical, Dental and Optical specialists as required.

	First parent / legal guardian	Second parent / legal guardian
Signature		
Title (e.g., Mr, Mrs, Ms)		
Name in full (Please include all names)		
Relationship to child		
Date		

Medical Consent

1. **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.
2. **Medical treatment:** I/We hereby give my consent for the School to act on my/our as necessary for my child's welfare if she requires a medical examination, medical testing or minor medical treatment such as attendance at a local GP, Doctor or Optician.
3. **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.
4. **The Administration of Medicines:** I/We hereby give my consent for appropriately qualified members of the School staff to administer prescription medication as listed in the Medication Section of the Medication and Treatment section of the Medical Information Form or as subsequently notified to the School and/or non-prescription medication such as Paracetamol, Ibuprofen, simple cough linctus, indigestion remedies and other over-the-counter remedies under protocols from the School's Medical Officer for treating minor ailments.

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

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