MEDICAL INFORMATION

This Statement of Health is **STRICTLY CONFIDENTIAL** between the Student and our Medical and Student Welfare Department. Please return this form to Newent Community School and Sixth Form Centre in a sealed envelope marked: **PRIVATE & CONFIDENTIAL FTAO Medical and Student Welfare Officer.**

BLOCK CAPITALS PLEASE

SURNAME :_____ FORENAME :_____ TUTOR GROUP : _____

ADDRESS:_____ HOME TEL NO: _____

_____ EMERGENCY TEL NO: _____

_____ DATE OF BIRTH: _____

DOCTOR'S SURGERY YOU ARE REGISTERED AT: _____

PLEASE TICK THE RELEVANT BOX	**YES**	**NO**
Has your child been absent from School for extended periods due to ill health in the last 2 years?	☐	☐
Has your child been under the care of a GP/Consultant in the last 5 years for long-term health condition?	☐	☐
Is your child Registered Disabled?	☐	☐
Is your child known to the School Nurse Team?	☐	☐
Is your child taking any long-term medication (please provide further details in box below?	☐	☐
Is your child receiving additional support in the form of;	☐	☐

- ☐ My Plan
- ☐ My Plan+
- ☐ Closed My Plan / My Plan+
- ☐ EHCP

If you have ticked YES to any of these questions, please give brief details. Please continue on separate paper if required.

Has your child ever suffered from any of the following? (Please circle and tick condition, as appropriate, and provide further details in box as necessary)	**YES**	**NO**
1. Allergies, including Hay Fever (please list allergies and severity in box provided below)	☐	☐
☐ Medication		
☐ Food		
☐ Other		
2. Asthma (if yes, please complete and return the Asthma Emergency Form attached)	☐	☐
3. Arthritis	☐	☐
4. Anaemia		
5. Anxiety; Depression; Panic Attacks; Self Harm, OCD or other Mental Health Concerns	☐	☐

Over ⊠

		YES	NO
6.	Bladder; Incontinence, Bowel Conditions; Ulcerative Colitis; Crohns; Constipation; Irritable Bowel (IBS)	☐	☐
7.	Cystic Fibrosis; Multiple Sclerosis; ME, Cerebral Palsy, Chronic Fatigue Syndrome	☐	☐
8.	Diabetes Type 1 (please provide Care Plan)	☐	☐
9.	Diabetes Type 2	☐	☐
10.	Dyslexia / Dyspraxia / A.D.H.D / A.D.D / Tourettes / ASD / ODD	☐	☐
11.	Eating Disorder; Anorexia; ARFID, Bulimia	☐	☐
12.	Eczema; Dermatitis; Psoriasis	☐	☐
13.	Epilepsy; Migraine; Fainting	☐	☐
14.	Heart Conditions; Angina; High Blood Pressure; Congenital Heart Defects	☐	☐
15.	Hearing Problems	☐	☐
16.	Hyper Mobility Disorder	☐	☐
17.	Reynards Syndrome	☐	☐
18.	Sciatica; Scoliosis	☐	☐
19.	Visual Impairment; Meares-Irlen Syndrome; Does your child wear spectacles /contact lenses?	☐	☐

If you have ticked YES to any of the above, or if your child has had any other serious illness or operation please give brief details and dates and indicate if the problem is still present.

☐ Please tick box if you consent to Paracetamol being administered to your child by The Medical and Student Welfare Officer.

☐ Please tick box if you consent to Piriton being administered to your child by The Medical and Student Welfare Officer.

☐ Please tick box if you DO NOT CONSENT to any of the above.

☐ Any medication to be taken in School time must be held securely by The Medical and Student Welfare Officer. Medication will be required to be in its prescribed box / bottle and accompanied by a letter of consent from parent / carer.

I declare that to the best of my knowledge I have answered the questions on this form accurately.

Parent / Carer Signature:_____ Date:_____

For Office Use Only to be completed by The Medical and Student Welfare Officer …… (Date)					
Paracetamol	Yes / No	Piriton	Yes / No	Medication	Yes / No