PAPPLEWICK SCHOOL, ASCOT

Confidential questionnaire to be completed and returned to the School Nurse, with your son's medical card.

NAME :	DATE OF BIRTH : TOWN AND COUNTRY OF BIRTH:

NHS NUMBER :	
PRESENT FAMILY DOCTOR:	
ADDRESS :	
TELEPHONE NO :	
IF FROM ABROAD PLEASE GIVE DATE FIRST RESIDED IN THE UK:	

1.	**Has your son had any of the following infections?**		**Dates :**
	Chicken Pox	Yes / No	
	Mumps	Yes / No	
	Measles/German Measles	Yes / No	
	Whooping Cough	Yes / No	
	Diphtheria	Yes / No	
	Any Other Infectious Diseases	Yes / No	

2.	**Inoculations and vaccinations**	**Please give details of most recent doses**
	Whooping Cough	
	Diphtheria	
	Tetanus	
	Polio	
	MMR	
	Tuberculosis	
	Any Others	

3.	**Does your son suffer from asthma or hayfever or eczema?**	**If so please give details of any medication.**
	Yes / No	

4.	Does your son have any drug sensitivities or allergies?	**If so please give details of any medication.**
	Yes / No	

5.	Are his hearing and sight normal? Does he wear glasses?	

6.	Has there been any bedwetting since infancy?	

7.	Does he have any dental problems?	

8.	Does your son have any chronic conditions e/g/ diabetes, epilepsy?	Please give details if so.
	Yes / No	

9.	Has he ever had any surgical operation or any serious medical condition?	Please give details if so.
	Yes / No	

10.	Please could you provide details concerning any past history of emotional problems which may be helpful to the matrons, should a boy be unusually upset.

11.	If hospital admission or a specialist's opinion is required please state whether you wish the treatment to be under the NHS, school health scheme or private health care. If private please provide details of insurance scheme and membership number.

12 CONSENT FOR TREATMENT AND SURGERY (*see notes prior to signing*).

Signed:	**Date:**

I hereby give consent for my son/ward to receive first aid and appropriate non-prescription medication – Paracetamol, , Ibuprofen, Simple Linctus, Sudafed and Piriton, TCP, Sudocrem, Arnica, Insect Repellent, Antihistamine Spray as authorised by the School Doctor, and for the school to seek medical, dental or optical treatment when required.

Signed:	**Date:**
Name:	**Home Tel No:**
Address:	
Mobile No: (Mother)	**Mobile No: (Father)**

A *Wherever possible, parents or guardians will be advised before a pupil is sent to hospital. Occasionally it is difficult to contact a parent. In such circumstances the headmaster will give consent, should emergency treatment or surgery be required.*

B *The school doctor will use his discretion in carrying out routine immunisation procedures. Should you have any special immunisation requirements please inform the School Nurse in writing.*

C *The school doctor will when necessary prescribe antibiotics unless otherwise informed. Please contact the School Nurse.*

*****OVERSEAS PARENTS - PLEASE ENSURE THAT ANY MEDICATION GIVEN TO THE SCHOOL NURSE IS ACCOMPANIED BY INSTRUCTIONS AND DOSAGE DETAILS FULLY TRANSLATED INTO ENGLISH. *****

If you have any further concerns throughout your son's boarding time at Papplewick please do not hesitate to contact the School Nurse, who will be happy to help: nurse@papplewick.org.uk