## PAPPLEWICK SCHOOL, ASCOT

 $Confidential\ question naire\ to\ be\ completed\ and\ returned\ to\ the\ School\ Nurse,\ with\ your\ son's\ medical\ card.$ 

NHS NUMBER: PRESENT FAMILY DOCTOR:  ADDRESS:  IFFROM ABROAD PLEASE GIVE DATE FIRST RESIDED IN THE UK:  I. Has your son had any of the following infections?  Chicken Pox  Mumps  Yes / No  Measles/German Measles  Yes / No  Diphtheria  Yes / No  Any Other Infectious Diseases  Whooping Cough  Diphtheria  Tetanus  Polio  MMR  Tuberculosis  Any Others  3. Does your son have any drug sensitivities or allergies?  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  1. 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  4. Does have any dental problems?	NAM	IE:		TOWN AND COUNTRY OF BIRTH		TRY OF BIRTH:			
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?  Chicken Pox Yes / No Mumps Yes / No Measles/German Measles Yes / No Diphtheria Yes / No Any Other Infectious Diseases Yes / No  2. Inoculations and vaccinations Whooping Cough Diphtheria Tetanus Polio MMR Tuberculosis Any Others  1. Has 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?									
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7. Does he have any dental problems?	6.	Has there been any bedwetting since infancy?							
7. Does he have any dental problems?		D 1 1 1 11 0							
	7.								
8. Does your son have any chronic conditions e/g/ diabetes, epilepsy? Please give details if so.	8.								
Yes / No									

9.	Has he eve	r 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.	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:							
Mobi	ile No: (Mo	ther)	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