Wycliffe College Pupil Health Form

Child's name: _____ Starting from: ____/____/____

This form will be retained by the Medical Centre staff but made available to those who care for your child whilst at Wycliffe.

Full name of child:

Known as:	**Male / Female**	**Date of Birth:** / / dd/mm/yyyy
Year group:	**Wycliffe House:**	
Child's Town of Birth:	**Child's Country of Birth**	

Does your child have or has your child had any of the following?	Please state **YES** or **NO**	If yes, please give any further information if necessary
Asthma		
Diabetes		
Epilepsy/ seizures		
Eczema		
Allergies		
Major illness		
Operations/ Surgery		
Hearing problems		
Visual problems		
Eye test		Date of most recent?
Is there anything else you feel we should be aware of?		

PLEASE ATTACH ANY FURTHER INFORMATION YOU FEEL WOULD BE USEFUL

Does your child use any regular medication? ***yes / no***

If yes: i) for what purpose? _____

ii) what is the name of the medication?_____

iii) how often is it used? _____

Will your child be bringing any medication into school? *Yes / no* (if yes, please give details):

_____

Should your child be restricted in any physical activities? *Yes / No* (if yes, please give details):

Please ensure that you complete all 5 pages in FULL

Is there any family history of cardiomyopathy or sudden death below the age of 35? *Yes/no*

If yes, please ensure that you enclose a letter from your doctor outlining the diagnoses and any further investigations that may have been carried out.

Vaccinations

It is essential that you provide the Medical Centre with a full vaccination history. If your child has not followed the NHS vaccination schedule you may find it easier to attach a copy of their vaccination history to this form. We would advise that you check the following website to see the childhood vaccinations that we would recommend your child receiving before they attend Wycliffe: http://www.nhs.uk/conditions/vaccinations/Pages/childhood-vaccination-schedule.aspx

Type	1st date	2nd date	3rd date	4th date	5th date
Diphtheria					
Tetanus					
Polio					
Pertussis (whooping cough)					
Hib					
Pneumococcal (PCV)					
Men B					
Men C					
HPV					
MMR					
Rotavirus					
Men ACWY					

BCG tuberculosis (TB)	
Tuberculin skin test/Mantoux	

Flu vaccine dates:

Please state any other immunisation and relevant dates:

Please let us know if there were any adverse reactions to any of the above immunisations

General Practitioner (GP) Details

Day Pupils	
Name of current NHS GP/ doctor:	
Address of current NHS GP/ doctor (including postcode) :	

Boarding Pupils	
Please attach a copy of your child's birth certificate or passport. Please also attach your child's NHS medical card. If this is not available, it is important that you complete your child's NHS number. You will have to contact your current GP for this information (this is only relevant for those children who have previously been registered with a NHS GP).	
Child's NHS number:	
Name of current NHS GP/ doctor:	
Address of current NHS GP/ doctor: (including postcode)	

Child's full address when they were registered with the above GP: **(including postcode)**
Please Note: Without this information we will not be able to register your child with a doctor

International Pupils Only – additional information			
Date when first resident in the UK:		**If previously resident in the UK, date of leaving:**	
If previously resident in the UK, please provide:			
Name of previous NHS GP/ doctor:			
Address of current NHS GP/ doctor: **(including postcode)**			
Please give address of previous UK residence **or previous school in the UK:** **(including postcode)**			

Confidential
Is there any other sensitive information you feel we should know about your child so that we are able to offer the most supportive care?
Would you like this information to remain: *please delete as appropriate* ***a.) To remain completely confidential?*** ***b.) To be passed on to the relevant staff in the school?***

If you would prefer to discuss this information with the school Nurse by telephone or email please refer to contact details below:

Declaration for parent (or adult with parental responsibility) completing the form

1. To the best of my knowledge and belief the above information is correct at the time of signing.
2. I agree to regularly update the Medical Centre of any changes to this information.
3. I understand that it is my responsibility to update contact details held by the school office.
4. I consent to emergency first aid treatment (including medical, dental and optical) if necessary.
5. I consent to appropriately trained staff to administer approved over-the-counter remedies and prescribed medication authorised by the medical Centre, where appropriate.
6. I recognise that my child has the right, under Fraser Guidelines, to be advised and treated in confidence if seen to be competent.

Signature: **Date:**

Name in Block Capitals:

Relationship to child:

Regardless of age group, in order to maintain continuity of care, please inform the Medical Centre of any medical problems, change or accidents which occur whilst your child is at home.

It is a legal requirement, that prior to your child starting at Wycliffe, this form is completed and signed. Please return the form by post to 'Medical Centre, Wycliffe College, Stonehouse, Gloucestershire, GL10 2JQ, UK. Alternatively, it may be scanned by email to Medcen@wycliffe.co.uk or faxed to the main school office at +44 (0) 1453 827634.