

DURHAM



SCHOOL

NEW PUPILS' MEDICAL QUESTIONNAIRE

THIS FORM MUST BE COMPLETED AND SENT TO THE SCHOOL

BEFORE THE PUPIL'S FIRST TERM

Surname of pupil.....

Other names.....
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Date of birth.....

Date of entry to School.....

House.....

Boarder or day pupil.....

Into which year group is your child joining.....

Contact details of pupil's GP (if pupil is or has been resident in UK)

Name.....

Address.....
.....

Telephone number.....

MEDICAL HISTORY OF CHILD

When returning this questionnaire, please provide **The Medical Centre** with a print out of your child's **vaccinations** which can be obtained from your **GP Surgery**.

Please note: Final booster injections against diphtheria, tetanus and polio should be given between the age of 14 and 15 years.

1. Has he/she resided abroad? If so, please give details of any infection with tropical disease.

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2. Please give details of any known exposure to active pulmonary tuberculosis.

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3. Is his/her sight normal? If not, please give details.

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4. Are glasses or contact lenses required for sport?

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5. Are his/her teeth normal? If not, please give details.

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6. Please indicate last dental check-up

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7. Are you willing for any necessary or routine vaccinations to be carried out by the GP practice linked to the School? (boarders only)

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8. Does he/she suffer or has he/she suffered from bed-wetting? If so, please give details of his/her present condition.

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9. Does he/she suffer or has he/she suffered from fits or epilepsy in any form? If so, please give details of treatments etc.

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10. Does he/she suffer or has he/she suffered from deafness, ear infection or discharge? If so, please give details of his/her present condition.

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11. Does your child suffer from regular sore throats/runny nose? Or have any conditions affecting nose or throat?

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12. Please give details of any history of allergic complaints, such as hay fever, asthma or eczema.

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13. Please list any medicines used to combat any such allergies above and any other medication your child is currently taking.

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14. Please give any known sensitivity or allergy to drugs or other substances

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15. Please give details and dates of any surgical operations.

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16. Has your child suffered from any serious medical illness or operation that has relevance to his/her medical/social welfare at school?

Yes / No

If you have answered **yes**, please send details of any ongoing medical care, care plan or consultant details applicable. This must be attached and returned with the medical questionnaire.

17. Is he/she fit in all respects for the usual games/sports played at school? If not, please give details of exceptions and reasons.

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18. Is he/she covered by any private insurance scheme for medical care?

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19. In the event of minor illness or injury, do you consent to the administration of simple remedy and pain relief (e.g. paracetamol, simple linctus, and ibuprofen?) Please note that we can only give ibuprofen without prescription to pupils over the age of 16.

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20. Are you willing for the information contained in this questionnaire to be shared confidentially with teaching staff in the interests of your child?

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PLEASE NOW SIGN AND RETURN THIS FORM TO THE MEDICAL CENTRE IN THE ENVELOPE PROVIDED BEFORE YOUR CHILD COMMENCES AT DURHAM SCHOOL.

Signature of parent or guardian.....

Date

Name of parent or guardian signing (block capitals please).....

Address.....

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Postcode.....

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Telephone numbers

Home.....

Work.....

Mobile.....

Fax.....

Thank you for taking the trouble to complete this form carefully