BEDSTONE
www.bedstone.org

MEDICAL HISTORY CARD
DAY SCHOLARS

SURNAME ……..Male/Female*

FORENAMES ……

DATE of ENTRY ……

DATE of BIRTH ……

HOME ADDRESS ……

……

…… Post Code……

TELEPHONE (1) …… …… (2)……

Mobile ……

Email ……

GP NAME & ADDRESS Dr……

……

……Telephone ……

Names of siblings in college ……

1. **Has your child had any of the following illnesses:**

Chicken Pox:	Yes/No	German Measles:	Yes/No
Measles:	Yes/No	Mumps:	Yes/No
Whooping Cough:	Yes/No	Otitis Media:	Yes/No
Middle Ear Disease:	Yes/No		

2. **Has your child required treatment for any of the following:**

Asthma:	Yes/No	Eczema:	Yes/No
Hay Fever:	Yes/No	Bone or joint disease:	Yes/No
Fits or Convulsions:	Yes/No	Diabetes:	Yes/No
Discharging ears:	Yes/No	Deafness:	Yes/No
Frequent sore throats:	Yes/No	Nasal obstruction:	Yes/No
Psychological problems:	Yes/No	Recurrent chest infections:	Yes/No

If the answer to any of the above is YES, please give details.

3. **Please give details of other illnesses, past injuries, operations or hospital investigations.**

4. **Please give details of any known allergy, including sensitivity to drugs:**

5. **Please give details of any dietary requirements we should be aware of:**

6. **Do you consider your child to be fit to take part in all normal school games and activities? Yes/No**

If the answer is no, please give details:

7. **Is your child at present under any form of medical treatment or takes regular medication**. **Yes/No**

If YES, please give details below and accompany this form with a letter from your doctor. For regular medication to be administered, the medical staff will contact you for further information and to sign the appropriate form.

We discourage children from carrying around medication in their belongings for health and safety reasons and request that parents/guardians contact the medical department to discuss any medication issues. In emergency situations or if your child is in pain or discomfort, we can administer pain relief in the form of Paracetamol and/or ibuprofen in various forms.

To consent, please read and sign the **Pupil Medical Consent** form which will be kept in your child's records within the medical centre and admissions office. **We cannot dispense any medication without prior consent**.

8. Does your child wear spectacles/contact lens **Yes/No**

9. Does your child suffer from colour blindness: **Yes/No**

10. Is your child undergoing dental treatment **Yes/No**

11. Does your child suffer travel sickness **Yes/No**

Comments:

12. Has your child been immunised against tetanus **Yes/No**

If **YES**, date of last booster

☐ I have read the above

Signature of Parent or Guardian .....

Date: .....