## Medical Centre and Consent Form

The College requires you to complete all sections of this form as fully as possible. The information provided by you in this form will help us to care for your child while they are a student at the school.

All information received on this form will be treated in confidence.

For more information about how the College may use your and your child's information contained in this form, please see our student privacy notice and our parent privacy notice which are published on the College website: https://[www.bedstone.org/policies/](http://www.bedstone.org/policies/)

Child's details

|  |  |
| --- | --- |
| Child's full name and gender: | M  F |
| Date of birth: |  |

Next of kin contact details

|  |  |
| --- | --- |
| Name: |  |
| Contact telephone number: |  |

Child’s doctor’s details

|  |  |
| --- | --- |
| Name of child's doctor: |  |
| Address of child's doctor: |  |
| Telephone number for child's doctor: |  |
| NHS number |  |

Eyesight and hearing

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does your child have an eyesight condition? (please tick one box) | Yes |  | No |  |
| Does your child have a hearing condition? (please tick one box) | Yes |  | No |  |
| If you have answered Yes to either question above, please provide details below: | | | | |
|  | | | | |
| If your child takes any medication for an eyesight or hearing condition, please provide details in the Medication section in this form. | | | | |

## Medical Centre and Consent Form - Continued

MEDICAL CONDITIONS – please tick relevant box. If yes to any of the below please provide us with more details in the boxes underneath

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does your child have any of the following conditions? | | | | |
| ALLERGIES to food, medication, animals or other known allergens?  (If yes, please detail to what and reaction experienced – ie, skin irritation, vomiting etc. Also see anaphylaxis below) | Yes |  | No |  |
|  | | | | |
| ANAPHYLAXIS (if yes, please indicate to what, when it occurred, what happened and what current medication your child carries) | Yes |  | No |  |
|  | | | | |
| ASTHMA (if yes, please indicate severity, any known triggers and inhalers used.) | Yes |  | No |  |
|  | | | | |
| DIABETES (if yes, please detail type, insulin and delivery system, i.e. injection or pump, or medication used.) | Yes |  | No |  |
|  | | | | |
| EPILEPSY (if yes, please indicate nature and frequency of seizures and any known triggers) | Yes |  | No |  |
|  | | | | |
| Mental health conditions (if yes, please provide details and any supporting measures/strategies required) | Yes |  | No |  |
|  | | | | |

## Medical Centre and Consent Form – Continued

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Musculoskeletal conditions which may impact on physical activity (If yes, please provide details ) | Yes |  | No |  |
|  | | | | |
| Other relevant condition(s) (details below) | Yes |  | No |  |
|  | | | | |
| If your child takes any medication or receives treatment for an above named condition, please provide full details in the Medication and treatment section below | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication / treatment | Reason for  Medication / treatment | Dosage  (if applicable) | Frequency |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Please note – all medication in school and the boarding houses must be seen/approved by the College nurses and signed permission obtained before use. This includes herbal and Chinese traditional medicines.**

|  |
| --- |
| If your child has special dietary requirements, unrelated to allergies, please provide details in the box below: |
|  |

## Medical Centre and Consent Form – Continued

Immunisation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| To the best of your knowledge has your child had all their preschool vaccinations including boosters according to the UK schedule? This covers diphtheria, tetanus, whooping cough, polio, hib, pneumococcus, meningitis B and C, rotavirus, mumps, measles and rubella.  Please provide dates of last MMR  Tetanus | Yes  …………….  ……………. |  | No |  |
| Please indicate any your child did not have: | | | | |
| Subsequently has your child been vaccinated against:  (please provide date where possible) | Yes | | No | |
| Human Papilloma Virus (HPV) (Girls and boys aged 12-13)  1st dose given ………. 2nd dose …… |  | |  | |
| Meningitis A,C,W and Y  (All pupils in Year 9) |  | |  | |
| Chicken Pox |  | |  | |
| Tuberculosis (TB) |  | |  | |
| Hepatitis B |  | |  | |
| Covid 19 |  | |  | |
| Influenza |  | |  | |
| Please list below any other vaccines your child has had. | | | | |
|  | | | | |

## Medical Centre and Consent Form - Continued

We have provided full and complete information about my/our child in this Medical Information Form.

We agree to inform the College in the event that my/our child's health or medication needs change.

Medical Consent

1. First Aid: I/We consent to appropriately trained and qualified members of the College staff to administer first aid to my/our child where appropriate.
2. Medical treatment: I/We hereby give consent for the College to act on my/our behalf as necessary for my child's welfare if s/he requires a medical examination, medical testing or minor medical treatment such as attendance at a local GP, Doctor (dentist) or Optician.
3. Emergency Medical Treatment: I/We give consent for the Head to act on our behalf to authorise emergency medical treatment as necessary for my child's welfare in the event I/we cannot be contacted in time.
4. The Administration of Medicines: I/We hereby give consent for appropriately qualified members of the College staff to administer prescription medication as listed in the Medication and Treatment section of the Medical Information Form or as subsequently notified to the College and/or non-prescription medication such as Paracetamol, Ibuprofen, simple cough linctus, indigestion remedies and other over-the- counter remedies under protocols from the College Doctor for treating minor ailments.

If there is any medication or remedies you would prefer your child not to receive please indicate these in the box below.

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
|  | First signatory | Second signatory |
| Signature |  |  |
| Title  (e.g. Mr, Mrs, Ms) |  |  |
| Name in full  (please include all names) |  |  |
| Relationship to child |  |  |
| Date |  |  |

College medical policies are available via the website. <https://www.bedstone.org/policies/>