



## Students Personal Medical Record

### Section 1

<b>Student Forenames:</b>	<b>Last Name:</b>
<b>Date of Birth:</b>	<b>Place of Birth:</b>
<b>Parental Address:</b>	<b>Fathers Address if Different:</b>
<b>Phone Number:</b>	<b>Phone Number:</b>
<b>Email Address:</b>	<b>Email Address:</b>

### Current GP Details

<b>Name and Address of Current GP:</b>

### Medication and Allergy History:

Does your child take any regular medication, prescribed or otherwise? (please list)	Does your child have any known allergies? (please list)

Is your child on the BUPA School Medical Insurance Scheme?

Yes

No

If no and you are using your own Private Health Insurance company please give the following information.

<b>Company Name</b>	<b>Membership Number</b>
<b>Please give name in which the policy is held, if held in the family name who is the main policy holder?</b>	

<b>Has your child ever suffered from or consulted a doctor about any of the following?</b>			
	<b>Yes</b>	<b>No</b>	<b>If YES please give details</b>
a) Any infectious disease, such as malaria or typhoid, but excluding ordinary childhood infections (i.e. chickenpox)			
b) Persistent cough, shortness of breath, asthma, hay fever, sinusitis, tuberculosis or any other disease of the respiratory system.			
c) Raised blood pressure, a heart murmur, or any other disease of the heart or circulation.			
d) Persistent indigestion or diarrhoea, appendicitis, hernia or any other disease of the abdomen.			
e) Any problems with the kidneys or genitor-urinary system, such as cystitis or problems with menstruation.			
f) Any disorder of the glands such as diabetes or a thyroid disorder.			
g) Anxiety, phobias, depression, medication with tranquillisers or treatment by a psychologist or psychiatrist.			
h) Is there a history of an eating disorder?			
i) Disorder of the eyes, ears or ears, or any neurological disorder such as recurrent headaches or migraines?			
j) Has the applicant ever been hospitalised or had a general Anaesthetic?			
k) Does your child bed wet?			
l) Does your child sleep walk?			
i) Has your child had an eye test?			Date of last test
ii) Dental Care			Date of last check up:
iii) Orthodontic care			Date of last treatment:
iv) Has your child ever had a hearing test?			If YES Pass / Fail

**1) Please give full details of any past injury or disease of the spine, or other bones, joints, muscles or ligaments, in particular back pain, or any previous injuries related to dancing or exercise. It is in your best interest to give full details particularly of any recurrent injury so that the medical team can help you resolve the problem.**

**2) Has your child received any other medical advice, treatment, investigations or treatment in hospital or from a Doctor, or are you contemplating any such treatment, about any other condition not mentioned above.**

**3) Are there any immediate family members who have had or are suffering for any of the following (please circle):**

**High Blood Pressure**

**Asthma**

**Diabetes**

**Epilepsy**

**Please indicate the applicants relationship to the family member:**

**4) To the best of your knowledge and belief is the applicant now in good health? If not, please give full particulars and any additional information that you feel that we should know.**

**Section 2**

**Consent for Medical Needs**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| 1) I consent to my child being prescribed medication by the school doctor.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) I consent to the school nurse administering appropriate Medication to my child.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) I consent to a Houseparent when necessary and appropriate Administering medication to my child.                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) I consent to my child receiving first aid treatment from an Appropriately qualified member of staff.                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) I agree to authorise Elmhurst Medical Centre to approve such Medical treatment for my child as is deemed necessary in an emergency. | <input type="checkbox"/> | <input type="checkbox"/> |

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Consent to the Administration of Medication.

Please note that the administration of all medication at Elmhurst School is carefully monitored, if you have any concerns please contact the school Medical Centre

Drug Name and use	Consent	Creams and Lotions	Consent
<b>Paracetamol – Tablet or liquid</b> Given for mild pain and to reduce temperatures.	Yes / No	Arnica – Cream: Used to reduce bruises.	Yes / No
<b>Ibuprofen – Tablet or liquid</b> Anti Inflammatory, used of muscular pain and reducing temperatures. <b>Will not be given to students with Asthma.</b>	Yes / No	<b>Witch Hazel – Lotion</b> Used to reduce bruises.	Yes / No
<b>Piriton – Tablets or Liquid</b> Antihistamine, helps to reduce allergic reactions, hay fever and skin rashes. <b>Will not be given to students with Epilepsy.</b>	Yes / No	<b>Benadryl – Cream</b> Used to treat skin rashes.	Yes / No
<b>Clarityn – Tablets</b> Antihistamine, once a day treatment for hay fever.	Yes / No	<b>E45 – Cream</b> For the treatment of dry skin.	Yes / No
<b>Strepsils – Lozenges</b> Relief for sore throats	Yes / No	<b>Vicks Vapo Rub.</b> Used to ease symptoms of catarrh.	Yes / No
<b>Lemsip – Powder</b> For treatment of colds. <b>Will not be used with other paracetamol based drugs.</b>	Yes / No	<b>Olbus Oil</b> Used as an inhalation to ease the symptoms of catarrh.	Yes / No
<b>Simple Linctus – Liquid</b> Relief for cough.	Yes / No	<b>Deep Heat Rub</b> Helps to ease muscular strains and sprains.	Yes / No
<b>Sudafed – Tablets</b> Reduces nasal congestion associated with colds and sinusitis.	Yes / No	<b>Biofreeze – Gel</b> Helps to ease muscular strains and sprains.	Yes / No
<b>Dioralyte – Powder</b> Used for replacement of essential water and salts, for those with dehydration.	Yes / No	<b>Fenbid 5% - Gel</b> Ibuprofen based topical gel, used to treat muscular pain. <b>Will not be given to students with Asthma.</b>	Yes / No
<b>Imodium – Tablets</b> Used to treat symptoms of diarrhoea.	Yes / No	<b>Sun Tan Lotion</b> <b>Where possible please provide your child with their own.</b>	Yes / No
<b>Joy Rides – Tablets</b> Used to help with motion sickness.	Yes / No	<b>After Sun Lotion</b> <b>Where possible please provide your child with their own.</b>	Yes / No

Parental Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_