

CONFIDENTIAL HEALTH QUESTIONNAIRE
INFORMATION FOR THE SCHOOL HEALTH TEAM ONLY

FULL AND WEEKLY BOARDING PUPILS

To the Parents

Please fill in this certificate so far as you can. Then hand it to your family doctor who will complete the record and carry out the medical examination. **Any fee incurred is payable by you, please.**

Oral and Dental Health

All dental treatment should be undertaken in the holidays. **Only emergency dental treatment can be offered in York, for which any dental fees incurred are payable by you, please.**

Optical care:

All optical treatment should be undertaken in the holidays. **Only emergency optical treatment can be offered in York, for which any fees incurred are payable by you, please.**

To the Family Doctor

Please forward this paper direct, using the envelope provided, to the School Medical Officer to arrive **at least two weeks** before the pupil is due to arrive.

The admission or retention of a pupil at the School is conditional upon acceptance of the following:-

Consent to Treatment

If a pupil requires special medical treatment, every effort will be made to obtain the prior consent of the parent or guardian or UK guardian, or the pupil, if aged 16 or over. Should this be impossible in the time available, the Headmaster or his deputy, acting **in loco parentis**, is authorised to give consent to such treatment (including anaesthesia or a surgical operation/procedure) as may be recommended by the School Medical Officer or his deputy.

All full and weekly boarders during their first year will have an introductory meeting with the School Medical Officer and the Bootham School Health Centre Team.

Immunisation against infectious disease may be required from time to time and individual consent will be sought from parents / guardians.

Special Medical Needs

The parents/guardians of all pupils attending the School who have a special medical need such as anaphylaxis, epilepsy or cerebral palsy etc., are required to complete and annually update a Health Care Plan (HCP), copies of which can be downloaded from the School website. The HCP will be shared with relevant school staff to ensure the pupil's individual needs are met.

Information

Throughout a pupil's time at the School, the School Medical Officer / School Nurse Manager shall have the right to give to the pupil's parents, guardian, or Headmaster, any confidential information if he / she considers that it is in the pupil's best interest or that it is necessary to do so for the health or protection of other members of the School community.

CONFIDENTIAL HEALTH QUESTIONNAIRE:

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TO THE PARENTS

FULL NAME OF PUPIL: _____
(Underline first name used)

NHS No: _____

DATE OF BIRTH: _____ **Place of Birth:** _____ **Sex: Male / Female**
(Please delete as applicable)

Home Address: _____

Full Tel No (Home) _____

Full Tel No (Business) _____

Email Address _____

Name & Address of UK Guardian (for overseas pupils)

Full Tel No _____

Email Address _____

NAME & ADDRESS OF GENERAL PRACTITIONER (GP): _____

Full Tel No (GP): _____

PLEASE UNDERLINE ANY OF THE FOLLOWING DISEASES WHICH THE PUPIL HAS HAD:

**CHICKENPOX
(PERTUSSIS)**

GERMAN MEASLES (RUBELLA)

WHOOPING COUGH

MUMPS

MEASLES

TROPICAL DISEASE (PLEASE STATE WHICH): _____

Please give details of immunisations against the following diseases:

Immunisations received	Schedule	Dates of all immunisations given (If no date is given we will assume not immunised)
Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio, Hib (a bacterial infection that can cause severe pneumonia or meningitis in young children) these are given as a combined 5-in-1 single injection	Usually given at 2 months	Date:
Pneumonia	Usually given at 2 months	Date:
5-in-1 (second dose)	Usually given at 3 months	Date:
Meningitis C	Usually given at 3 months	Date:
5-in-1 (third dose)	Usually given at 4 months	Date:
Pneumonia (second dose)	Usually given at 4 months	Date:
Meningitis C (second dose)	Usually given at 4 months	Date:
Meningitis C (third dose)	Usually given at 12 months	Date:
Hib (fourth dose)	Usually given at 12 months	Date:
M.M.R. (Measles, Mumps, Rubella) given as a single jab	Usually given at 13 months	Date:
Pneumonia third dose	Usually given at 13 months	Date:
Diphtheria, tetanus, pertussis and polio pre-school booster	Usually given aged 4-5 yrs	Date:
M.M.R. (Measles, Mumps, Rubella) pre-school booster	Usually given aged 4-5 yrs	Date:
Hepatitis A (usually given as a travel vaccination):		Date:
Typhoid (usually given as a travel vaccination):		Date:
Tetanus Diphtheria/Polio (Td/IPV) booster jab	Usually given aged 13/18 yrs	Date:
TUBERCULOSIS (BCG) (PROOF OF THIS WILL BE REQUIRED FOR PUPILS FROM OVERSEAS)	Date:	
PLEASE DETAIL ANY OTHER VACCINATION RECEIVED NOT ALREADY SPECIFIED, E.G. YELLOW FEVER, RABIES, HEP B	PLEASE LIST AND GIVE DATE OF ADMINISTRATION:	

Human papillomavirus (HPV), girls only, three jabs given within eight months		
HPV (first dose)	Usually given aged 12-13 yrs	Date:
HPV (second dose)	Usually given aged 12-13 yrs	Date:
HPV (third dose)	Usually given aged 12-13 yrs	Date:

Please say whether, in the event of a pupil needing an urgent operation or a consultation with a specialist, you wish it to take place at the local hospital (National Health Service [NHS]) or privately under for example, BUPA or PPP.

Please underline your choice: **NHS** **BUPA** **PPP** **OTHER**

Has the pupil lived overseas (outside the UK)? **YES/NO** (*please delete as appropriate*)

If so, please state **country** and give details of any **tropical infection** the pupil may have contracted / sustained.

Please give details if the pupil has had any known exposure to active pulmonary tuberculosis: _____

Does the pupil have a colour vision deficiency? **YES/NO**

If yes please give full details:

Does the pupil have any hearing problems? **YES/NO**

If yes please give full details:

Has treatment been required for any of the following conditions?

	YES	NO		YES	NO
Asthma (*If yes, give full details)			Deafness (*If yes, give full details)		
Eczema (*If yes, give full details)			Frequent Sore Throat (*If yes, give full details)		
Hay Fever (*If yes, give full details)			Psychological Problems (*If yes, give full details)		
Bone or Joint Disease (*If yes, give full details)			Epilepsy, seizures, or Convulsions (*If yes, give full details)		
Diabetes (*If yes, give full details)			Anaphylaxis (*If yes, give full details)		

***RE THE ABOVE TABLE, IF YOU HAVE RESPONDED YES TO ANY OF THE ABOVE CONDITIONS PLEASE GIVE FULL DETAILS REGARDING THE PRESENTATION OF THE CONDITION AND TREATMENT RECEIVED:**

Please give full details of any other illness, operation, hospital investigation, injury or congenital condition / disability:

Please give details of any known allergy, including sensitivity to drugs, its severity and any prescribed medication if applicable:

Please give details of any history of asthma, eczema, hay fever, its severity and any prescribed medication if applicable:

Is there any serious / significant difficulty in learning to read or write? _____

Is there any history of physical or mental illness in the family which might have a bearing on health?

(E.g. early cardiac problems) _____

Is there a history of fainting episodes? If so, please give full details:

Is there any concern regarding the pupil's physical and/or mental/emotional health which you feel the School Doctor / Bootham School Health Team should be aware of, or which you would like to discuss?

IS THE PUPIL AT PRESENT UNDER ANY FORM OF MEDICAL/PSYCHOLOGICAL TREATMENT?

TO ENSURE THE PUPIL RECEIVES THE APPROPRIATE CARE THE BOOTHAM SCHOOL HEALTH CENTRE TEAM NEEDS A WRITTEN CONSENT TO BE IN PLACE FOR THE FOLLOWING **THREE** ELEMENTS:

1. **CONSENT TO TREATMENT:** If a pupil requires medical treatment, every effort will be made to obtain the prior consent of the parent/guardian/UK guardian, or of the pupil, if aged 16 or over. Should this be impossible in the time available, the Head Teacher or his deputy, acting in loco parentis, is authorised to give consent to such treatment (including anaesthesia or a surgical operation/procedure) as may be recommended by the School Medical Officer or his deputy.

*I consent / do not consent for the Head Teacher/Deputy Head to authorise for my son / daughter to receive necessary medical care, including anaesthesia or a surgical operation/procedure, if the school is unable to contact me to gain consent in an emergency.

*** PLEASE DELETE AS APPROPRIATE re consent for treatment**

Please note that the admission or retention of a pupil at the School is conditional upon acceptance of the above.

Please continue overleaf:

2. **INFORMATION SHARING:** The information given in this health questionnaire is regarded as confidential. However, there are certain medical conditions which may affect the day-to-day living of the pupil and relevant members of staff will need to be aware of this. For example, these may include epilepsy, diabetes, anaphylaxis, allergies and asthma. (This is not a definitive list.)

Additionally, it is important that the teaching staff are informed about a pupil with a colour vision deficiency problem, as in examinations for subjects such as geography, map coloured coding is used and special arrangements need to be put in place so as not to disadvantage such pupils.

* **I consent / do not consent** for information to be shared.

*** PLEASE DELETE AS APPROPRIATE re information sharing**

3. **ADMINISTRATION OF MEDICATION:** Our School Doctor has approved a limited list of non-prescription medicines to be given by the health centre staff. These are given for minor ailments such as headache, stomach-ache and nasal congestion, according to agreed protocols.

* **I consent / do not consent** for the pupil to receive non-prescription medicines from trained/authorised school staff according to an agreed protocol.

*** PLEASE DELETE AS APPROPRIATE re the administration of non-prescribed medicines.**

PLEASE DELETE AS APPROPRIATE TO GIVE / DECLINE CONSENT RE THE ABOVE, THEN PLEASE SIGN BELOW TO GIVE WRITTEN PERMISSION FOR THE ELEMENTS YOU HAVE CONSENTED TO:

SIGNATURE OF PARENT OR GUARDIAN _____

DATE: _____

The above signature authorises consent for the elements above which the parent / guardian has indicated they consent to by deleting as appropriate.

BEFORE YOU RETURN THIS FORM TO THE SCHOOL PLEASE ENSURE THAT YOU HAVE:

- **COMPLETED ALL QUESTIONS**
- **INDICATED WHETHER OR NOT YOU CONSENT TO THE THREE CARE ELEMENTS DETAILED ABOVE**
- **SIGNED THE DOCUMENT TO AUTHORISE THE CONSENTS YOU HAVE GIVEN VIA DELETING APPROPRIATELY**

IF THERE IS A CHANGE IN THE MEDICAL CIRCUMSTANCES OF THIS PUPIL DURING THE TIME HE/SHE IS AT BOOTHAM SCHOOL WOULD YOU KINDLY INFORM THE BOOTHAM SCHOOL HEALTH CENTRE TEAM.

TO THE MEDICAL ATTENDANT/GENERAL PRACTITIONER

Particulars of Medical Examination

EYES and VISION	Vision Right Left 6/ 6/ Refraction errors? Yes / No Any other problems? (details below) Yes / No
EAR, NOSE AND THROAT	Hearing normal Yes / No Nose normal Yes / No Any previous injury? Any gland problems? Yes / No Tonsils normal / enlarged / removed Any other problem:
CHEST	Heart Lungs Blood Pressure /
ABDOMEN	Any abnormality? Yes / No
URINALYSIS (check for sugar or Albumin)	Normal Yes / No
MUSCULO-SKELETAL SYSTEM	Any known problems Yes / No
FOR FEMALE STUDENTS	Age menarche (if known) Any period problems Yes / No Any other Gynaecological issues Yes / No
ANY MORE DETAILS REGARDING THE ABOVE? ANY OTHER WEAKNESS, DISEASE OR DISABILITY?	

ANY OTHER DETAILS OF PAST ILLNESSES OR PROBLEMS (FOR EXAMPLE, SEIZURES, SPEECH PROBLEMS OR PSYCHOLOGICAL CONDITIONS, ASTHMA, HAY FEVER OR ECZEMA)?	
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If the pupil requires any special measures and / or care, please give full details:

Signature of Medical Attendant/General Practitioner: _____

Date of Medical Examination: _____

Practice Stamp: