



JAMES ALLEN'S GIRLS' SCHOOL

WHOLE SCHOOL MEDICAL QUESTIONNAIRE FOR NEW ENTRANTS

SURNAME:	FIRST NAMES:
ADDRESS:	
TELEPHONE NO:	DATE OF BIRTH:
NHS NUMBER:	YEAR OF ENTRY TO JAGS/JAPS:

RECORD OF IMMUNISATIONS:	
TYPE	DATE(S)
Diphtheria, Tetanus, Whooping cough, Polio	
Meningitis C	
Measles, Mumps, Rubella (MMR)	
Human Papilloma Virus (HPV)	
BCG	
<i>Any other immunisations – please list</i>	

PLEASE GIVE DETAILS OF THE FOLLOWING:
Any allergies or sensitivities to food, medication, plasters, pets or to insect stings:
Any chronic or recurring medical conditions needing regular or occasional medication or treatment e.g. Asthma, Epilepsy:
History of any serious illnesses or injuries (including head injuries) requiring admission to hospital:
Any other medical conditions that might affect your child in her school life:
Are there any psychological factors that affect your child of which we should be aware e.g. eating disorders, recent close family bereavement?
Date of last dental check? Does she wear a dental appliance?

Date of last eye test:	Does she wear glasses?	Any problems with hearing:
<p>Please record any problems your daughter has with periods (where age appropriate):</p> <p>Any other problem/concern not recorded above:</p> <p>Can your daughter participate fully in games and PE? If no, please specify limitations/reason:</p>		
<p>General Practitioner's name:</p> <p>Address (inc post code):</p> <p>Telephone No:</p>		

PLEASE COMPLETE THE FOLLOWING SECTION

CONSENT TO GENERAL TREATMENT AND TO FIRST AID

I give consent for my daughter to receive any necessary general health care and first aid services provided at the School under the supervision of the qualified School Nurses. She may be given first aid treatment by any qualified member of staff.

Where appropriate she may be given non-prescribed medicines to treat minor illness or injury, these may include: Paracetamol (inc Calpol), Ibuprofen, throat lozenges, Piriton (in response to sudden allergic reactions), topical applications including Anthisan cream or Waspeze (bites/stings), Arnica cream (for bruises).

If you have any objections to any of the above please indicate.

I understand that essential medical information will be shared with school staff to ensure my daughter's safety e.g Asthma, Diabetes, Allergies.

I understand that it is my responsibility to write to the School Nurses informing them of any new medical conditions/health needs. Unless notification is received, the School is entitled to consider that the information in this Medical Questionnaire is correct.

Signature of parent/guardian:

Name of parent/guardian (please print clearly):

Date: