LUCTON SCHOOL

# MEDICAL RECORD

| Pupil Full Name | |
|---|---|
| Date of Birth | |

**This medical record booklet must be completed in full and the declaration signed and returned before the pupil starts school**

| DECLARATION |
|---|
| *I agree to the following information being kept by Lucton School.*<br>✓ *I hereby give permission for authorised school staff to take whatever action they may consider necessary for the immediate health and/or safety of my son/daughter in the event of a serious illness or injury.*<br>✓ *I also give permission for authorised school staff to administer paracetamol tablets or other simple medicines when judged to be absolutely necessary.*<br>✓ *I also give permission for authorised staff to administer first aid when necessary.* |

| **Pupil Name (PRINT)** | |
|---|---|

| **PARENT DETAILS** | **PARENT / GUARDIAN 1** | **PARENT / GUARDIAN 2** |
|---|---|---|
| **Parent Name (PRINT)** | | |
| **Parent Signature** | | |
| **Relationship to Pupil** | | |
| **Home Address** | | |
| **Post Code** | | |
| **Home Telephone** | | |
| **Mobile Telephone** | | |
| **Work Phone** | | |
| **Email Address** | | |

| **EMERGENCY CONTACT** | | | |
|---|---|---|---|
| *Please give details below who you would like to be contacted should there be an EMERGENCY and the school is unable to contact either of the above.* | | | |
| **Name** | | **Relationship to Pupil** | |
| **Address** | | | |
| **Home Telephone** | | **Mobile Phone** | |
| **Work Phone** | | **Email** | |

| BASIC HEALTH INFORMATION | | | | |
|---|---|---|---|---|
| DOCTOR | National Health Number (UK pupils) | | | |
| | Name of Doctor | | | |
| | Address of Doctor | | | |
| | Postcode | | Telephone | |
| DENTIST | Does the pupil wear a brace? | | | |
| | If Yes, please give details. | | | |
| | Name of Dentist | | | |
| | Address of Dentist | | | |
| | Postcode | | Telephone | |
| OPTRICIAN | Does the pupil wear glasses? | | | |
| | If Yes, should they be worn at school? | | | |
| | Name of Optician | | | |
| | Address of Optician | | | |
| | Postcode | | Telephone | |
| AUDIOLOGIST | Does the pupil have hearing problems? | | | |
| | If Yes, please give details | | | |
| | Name of Audiologist | | | |
| | Address of Audiologist | | | |
| | Postcode | | Telephone | |

| MEDICAL CONDITIONS | | | | |
|---|---|---|---|---|
| ASTHMA | Does the pupil suffer from Asthma? | | | |
| | Name of Consultant | | | |
| | Triggers/Details | | | |
| | Medication | | | |
| | Dose | | Frequency | |
| HAYFEVER | Does the pupil suffer from Hayfever? | | | |
| | Triggers/Details | | | |
| | Medication | | | |
| | Dose | | Frequency | |
| ALLERGIES | Is the pupil allergic to any Medication? | | | |
| | If Yes, please give details | | | |
| | Does your child suffer from any Allergies, excluding food? | | | |
| | If Yes, please give details | | | |
| | Does the pupil suffer from any Food Allergies? | | | |
| | If Yes, please give details | | | |
| OTHER AILMENTS | Does the pupil suffer from any other Ailments? | | | |
| | If Yes, please give details | | | |
| | Triggers/Details | | | |
| | Medication | | | |
| | Dose | | Frequency | |

| ADDITIONAL INFORMATION | | |
|---|---|---|
| **Has the pupil lived overseas?** | | |
| **If Yes, please give full details** | | |
| **Has the pupil had any operations?** | | |
| **If Yes, please give details including dates** | | |
| **ADDITIONAL SUPPORT** | **Does the pupil have an Educational Psychologist's report?** | |
| | **If Yes, please give details** | |
| | **Does the pupil have a learning support plan?** | |
| | **If Yes, please give details** | |
| | **Does the pupil have any social, emotional, behavioural problems?** | |
| | **If Yes, please give details** | |
| | **Boarding pupils only**<br>**Does the pupil wet the bed?** | |
| | **If yes, please give details** | |

| ILLNESSES | | | |
|---|---|---|---|
| *Has the pupil had any of the following? If Yes, please provide details and dates.* | | | |
| **Chicken Pox** | YES | NO * | |
| **Rubella (German Measles)** | YES | NO * | |
| **Measles** | YES | NO * | |
| **Mumps** | YES | NO * | |
| **Whooping Cough** | YES | NO * | |
| **Any tropical disease?** | YES | NO * | |
| **Covid-19** | YES | NO * | |
| **Any other disease?** | YES | NO * | |

| IMMUNISATION RECORD | | |
|---|---|---|
| *Please complete the following in as much detail as possible. Please do supply further information you feel would be of benefit using additional paper.* | | |
| **When to Immunise** | **Disease Protected against** | **Date of Immunisation** |
| Two months old | Diphtheria, tetanus, pertussis (whooping cough)<br>Polio and *Haemophilus influenzae* type b (Hib)<br>Pneumococcal infection (13 serotypes)<br>Meningococcal group B (MenB)[1]<br>Rotavirus gastroenteritis | |
| Three months old | Diphtheria, tetanus, pertussis, polio and Hib<br>Meningococcal group C disease (MenC)<br>Rotavirus | |
| Four months old | Diphtheria, tetanus, pertussis, polio and Hib<br>Pneumococcal (13 serotypes<br>MenB[1] | |
| Twelve months old | Hb and MenC<br>Pneumococcal<br>Measles, mumps and rubella (German measles)<br>MenB[1] | |
| Two to six years old (including children in school years 1 and 2) | Influenza (each year from September) | |
| Three years four months old or soon after | Diptheria, tetanus, pertussiss and polio<br>Measles, mumps and rubella | |
| Girls aged 12 to 13 years | Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11) | |
| Twelve plus | Covid-19 | |
| Fourteen years old (school year 9) | Tetanus, diphtheria and polio<br>Meningococcal groups A, C, W and Y disease | |
| Any other Vaccinations (if applicable) | | |
| **ADDITIONAL INFORMATION** | | |
| **Please provide any further medical information about your child on an additional sheet.** | | |