

BROCKWOOD PARK SCHOOL

CONFIDENTIAL MEDICAL RECORD

As parent or guardian, please would you complete the attached Medical Record and return it to us as soon as possible.

All students at Brockwood Park are required to be registered with the UK National Health Service so that full use can be made of the facilities available, especially in emergencies. **In order to make sure your child receives the correct treatment we must have this form completed and on file.**

Non-prescription medicines (alternative medicines) are given at the school by the person responsible for healthcare. We can arrange for a student to visit a homeopathic doctor privately, but there will be a charge and this doctor might not be available for accidents or emergencies. Please note that any medications issued by the School Infirmary will be charged to the student's sundries account (ie. hayfever tablets, paracetamol etc).

Student details:			
Surname:		First Name:	
Sex:	Male / Female	Date of Birth:	
Place of Birth:			

Person to contact in an emergency (<i>please print</i>)			
Name			
Relationship to student:			
Telephone:		Fax:	
Email:			
Address			

Signature of Parent or Guardian			
Dated:			
Name & Address of Current Doctor			
Telephone:		Fax:	

Should the occasion arise that your son/daughter may need emergency medical treatment and it proves impossible to contact you immediately, it is required by the Department of Social Security (D.S.S.) that we have your written permission to act in loco parentis should emergency treatment be necessary. The most usual course of action would be to take your son/daughter to the Royal Hampshire County Hospital in Winchester.

I give my permission for Brockwood Park School to act in loco parentis for emergency treatment for my son/daughter.

Signed: (Parent / Guardian)

..... (Parent / Guardian) Dated:

Please supply details of the following:

Significant illnesses, operations, injuries and hospital investigations:					
Has he/she had:	Measles?	German measles (Rubella)?			
	Chickenpox?	Mumps?			
Allergies and drug sensitivities:					
Does he/she suffer from any allergies?					
	Asthma?	Eczema?			
	Hay fever?	Medication/drugs?			
	Foodstuff?				
Please provide details:					
Any other allergies:					
Present medication, if any:					
Does he/she take regular medication of any kind? Yes* / No					
*Please provide details:					
Hearing / Sight:					
Is his/her hearing normal? Yes / No*					
*Please provide details:					
Is his/her sight good? Yes / No*					
*Please provide details:					
Any restrictions on ability to undertake the normal programme of sport, work and study?					
Do you wish your child to have private treatment? <i>(please delete as appropriate)</i>					
Dental:	Yes/No	Ophthalmic:	Yes/No	Natural remedies (specify):	Yes/No

Signature of Parent or Guardian:				Date:
Has your child been immunised against any of the following? Please give dates:				
Diphtheria:	day/	month/	year	
Tetanus:	day/	month/	year	(Booster)
Poliomyelitis:	day/	month/	year	(Booster)
Measles or combined Measles/Mumps/Rubella (specify)	day/	month/	year	
Whooping Cough:	day/	month/	year	

This form will be kept with your child's school records as well as at the local Doctors Surgery.