To be completed by school:
Registration No:
Date of entry:
Date of leaving:

Pupil Health Assessment Form

PUPIL'S DETAILS			
Surname:		**Forename:**	
Date of Birth:		**Surgery and GP Name:**	
Postcode:	**Home Address:**	**Surgery Postcode**	**Surgery Address:**

CONSENTS (Please ensure to sign/name and date each agreement/ consent/ declaration in this section)			
		Signature/Name Parent /Guardian	**Date**
I consent to my child having periodic health and wellbeing assessments with the School Welfare Officer	Yes ☐ No ☐		
I consent to my child receiving: • Paracetamol tablets/suspension	Yes ☐ No ☐		
• Ibuprofen tablets /suspension	Yes ☐ No ☐		
• Throat lozenges	Yes ☐ No ☐		
• Antihistamine cream	Yes ☐ No ☐		
• Antihistamine tablets/oral liquid	Yes ☐ No ☐		
I consent to my child receiving routine first aid and medical treatment as required from the School Welfare Officer & First Aiders	Yes ☐ No ☐		
I consent to my child receiving urgent or emergency treatment from the School Welfare Officer or a First Aider or emergency services or other medical professionals, including the use of anaesthetic, if the need arises. I understand that the school will try to contact me in advance of this, but that the health of my child will be the school's first concern.	Yes ☐ No ☐		
I will inform the school in writing of any changes to my child's health, or any changes to the information on this form.	Yes ☐ No ☐		
I will inform the school and complete the 'Administration of Prescribed Medications' form if my child requires any other medication	Yes ☐ No ☐		

DECLARATION

In accordance with the School Welfare Officer's professional obligations, medical information about pupils, regardless of their age, will remain confidential in most circumstances. However, it may be necessary to share medical information on a strictly need-to-know basis in order to protect the pupil's vital interests e.g. with a member of the Senior Management Team at the school, other healthcare professionals, or the parent concerned. As far as possible, the pupil will be informed of such circumstances if they arise.

I acknowledge the above policy on confidentiality. I also agree that the information on this form shall be held by the school/School Welfare Officer as my child's school Medical Record and that relevant information may be passed to staff to inform them of any medical condition that may affect my child during the school day to enable them to act in their best interest.

Signature/Name Parent /Guardian:	**Date:**

/Cont…

CURRENT MEDICAL INFORMATION CONTINUED		
		Details/ Treatments/ Medications (continue on separate sheet if necessary)
Does your child have any illness or condition or disability that might affect regular attendance at school?	Yes ☐ No ☐	
Asthma	Yes ☐ No ☐	
If yes to Asthma, is your child receiving current treatment?	Yes ☐ No ☐	

If YES to Asthma, or if your daughter has been prescribed an inhaler please complete this emergency inhaler consent (IF YOUR CHILD DOES **NOT** HAVE AN INHALER, PLEASE IGNORE THIS CONSENT REQUEST)	
CONSENT: **Use of Emergency Salbutamol Inhaler for Children already prescribed inhalers.**	
From 1st October 2014 the **Human Medicines (Amendment) (No. 2) Regulations 2014** allows schools to buy salbutamol inhalers, without prescription, for use in emergencies. The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication. If your child falls into the above category, we need written permission to use the school's emergency inhaler should the need arise, and if their usual inhaler is not available (for example, because it is broken, or empty).	
Child's name:	
I can confirm that my daughter has been diagnosed with asthma	Yes ☐ No ☐
Or, if your daughter has not been diagnosed with asthma	
I can confirm that my daughter has been prescribed an inhaler but is not a diagnosed asthmatic	Yes ☐ No ☐
In the event of my child displaying symptoms of asthma, and if her inhaler is not available or unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.	Yes ☐ No ☐
Signature/Name **Parent /Guardian:**	**Date:**

/Cont…

CURRENT MEDICAL INFORMATION CONTINUED		
		Details/ Treatments/ Medications (continue on separate sheet if necessary)
Hayfever	Yes ☐ No ☐	
Eczema	Yes ☐ No ☐	
Epilepsy / fits / convulsions	Yes ☐ No ☐	
Diabetes If YES, are they insulin-dependent?	Yes ☐ No ☐	
Anaphylaxis Do they carry an adrenaline pen – e.g.: Epipen, Jext, Emerade?	Yes ☐ No ☐	

If YES to Anaphylaxis, please complete this Adrenaline Auto Injector Device consent

(IF YOUR CHILD DOES **NOT** HAVE AN ADRENALINE AUTO INJECTOR DEVICE PLEASE IGNORE THIS CONSENT REQUEST)

CONSENT

Use of Emergency Adrenaline Auto Injector Device for Children already prescribed Adrenalin Auto-Injector Devices

From 1st October 2017 the Human Medicines (Amendment) Regulations 2017 allows schools to buy adrenaline auto injector (AAI) devices, for use in emergencies.

The emergency AAI should only be used on pupils who are known to be at risk of anaphylaxis, and for whom both medical authorisation and written parental consent for use of the emergency AAI has been given.

Child's name:	

Consent		**Additional Required Information**
I confirm that your daughter has been diagnosed with anaphylaxis and has been prescribed an AAI	Yes ☐ No ☐	Please state brand and strength of AAI device your child has been prescribed with:
I confirm that medical authorisation has been given for an emergency AAI to be used on my child in an emergency (please attach a copy of the authorisation to this document)	Yes ☐ No ☐	Please attach a copy of the medical authorisation for emergency AAI to be used to this document
In the event of my child displaying symptoms of anaphylaxis, and if her AAI is not available or unusable, I consent for my child to receive adrenalin from an emergency AAI held by the school for such emergencies.	Yes ☐ No ☐	
Signature/ Name **Parent /Guardian:**		**Date:**

/Cont…

CURRENT MEDICAL INFORMATION CONTINUED		
		Details/ Treatments/ Medications (continue on separate sheet if necessary)
Any known allergies – e.g.: insect bites, nuts, food, antibiotics etc.?	Yes ☐ No ☐	If YES, what are the symptoms, what is the treatment?
Hearing and / or visual problems	Yes ☐ No ☐	
Menstrual or gynaecological problems	Yes ☐ No ☐	
Severe headaches or migraine	Yes ☐ No ☐	
Growth or weight problems	Yes ☐ No ☐	
Anxiety or depressive tendencies	Yes ☐ No ☐	
Any medical condition problems which may affect participation in sport or physical education	Yes ☐ No ☐	
Travel sickness	Yes ☐ No ☐	
Are there any medicines (including inhalers and creams) that your child takes on a regular basis; if so do these need to be taken during school hours?	Yes ☐ No ☐	Please list the medicines regularly taken:
Does your child have any dietary requirements e.g. Halal, no pork, no beef, vegetarian, gluten free	Yes ☐ No ☐	

Family Medical History		
		Details of family member/ treatment
Serious illness	Yes ☐ No ☐	
Family circumstances that may impact your child at school?	Yes ☐ No ☐	
Health and Social Agencies		
Are there any medical, health or social professionals currently working with your child?	Yes ☐ No ☐	
Is your child is adopted, or not currently living with her birth parents	Yes ☐ No ☐	

Are there any other physical or mental health, medical, social or welfare issues that may affect your child at school? If yes, please provide details below (continue on separate sheet if necessary)	Yes ☐ No ☐
Signature/Name **Parent /Guardian:**	**Date:**

/Cont…

Immunisation History		
Immunisation	**Yes/No**	**Dates of Vaccination**
Tdap – Tetanus, Diphtheria, Polio, Pertussis	Yes ☐ No ☐	
Haemophilus influenzae b (Hib)	Yes ☐ No ☐	
Mumps / Measles / Rubella (MMR)	Yes ☐ No ☐	
Men C	Yes ☐ No ☐	
Men ACWY	Yes ☐ No ☐	
BCG	Yes ☐ No ☐	
Flu nasal spray	Yes ☐ No ☐	
Other:	Yes ☐ No ☐	
Signature/ Name Parent /Guardian:		**Date:**

END OF PUPIL HEALTH ASSESSMENT FORM