**Please answer all questions in full**

**Where possible any supporting medical documents should be sent with this form.**

| Surname | Other Names |
|---|---|
| | |
| | |
| Date of Birth (Day/Month/Year) | Sex (Male/Female) |
| | |

Part 1 (Tick one of the stated options below)

## a. Prescription Medication

Does your child take any regular medication which he/she will bring with him/her? Please tick yes / No

If yes, please give details below.

.....

.....

.....

I would like the House parent to administer my child's medication and I give my consent for him/her to do so.

My child is able to administer his/her own medication and I give my consent for him/her to do so.

**b. Emergency Medical Treatment**

In case of a medical emergency, every effort will be made to contact the child's parent or guardian as quickly as possible. If your child needs an emergency operation, do you give consent for the principal or a designated person from the school to sign the necessary consent form?

Yes No

If no, please advise on the action you would like the college to take.

**c. Dietary Requirements**

Please state any specific dietary requirement we must take into consideration for your child.

.....
.....
.....
.....

Does your son/daughter have any specific learning difficulties i.e. Dyslexia, Dyspraxia, Dyscalculia, or Attention Deficit Hyperactivity Dis-order? Yes No

Details.....
.....

Part 2 (To be completed by all students/parents if student is under 18 years of age)

| **Please answer all of the questions by ticking the box** | **Yes** | **No** |
|---|---|---|
| Do you regularly attend hospital or see a doctor | | |
| **Are you suffering from or have you ever suffered from:** | **Yes** | **No** |
| Any conditions relating to your heart or circulation? | | |
| Any respiratory problems? (e.g. Asthma) | | |
| Any psychological problems? (e.g. eating disorder/depression/self-harm) | | |
| Any eyesight condition that cannot be corrected by wearing glasses or contact lenses? | | |
| Any ongoing hearing problems or ear disorders? (e.g. Tinnitus) | | |
| Any ongoing bone, muscle or joint problems? (e.g. Recurrent back pain/Arthritis) | | |
| Any skin diseases or conditions that require medical treatment? | | |
| Any gastro-intestinal or abdominal problems? (e.g. Hernia/Gall stones) | | |
| Any blood or metabolic dis-orders? (e.g. Anaemia/Diabetes) | | |
| Any neurological conditions? (e.g. Severe headaches/vertigo/epilepsy) | | |
| Any long term or debilitating illness? (e.g. Multiple Sclerosis) | | |

If you have answered **yes** to any of the above, please complete Part 3. If you answered **No** to all questions in Part 2, please sign and date at the end of this part of the questionnaire.

..... .....

Signature Date

Part 3

| **Heart and Circulation** | Yes | No | Details |
|---|---|---|---|
| Heart Attack | | | |
| Angina | | | |
| Other heart disease or abnormal heart rhythm | | | |
| Chest pain | | | |
| Stroke/Mini stroke | | | |
| High blood pressure | | | |
| Palpitations | | | |
| **Respiratory** | **Yes** | **No** | **Details** |
| Shortness of breath or coughing | | | |
| Bronchitis | | | |
| Asthma | | | |
| Any other lung dis-order | | | |
| Do you smoke? | | | |
| **Psychological Health** | **Yes** | **No** | **Details** |
| Nervous breakdown, panic attacks,phobias,neurosis | | | |
| Psychosis,Schizophrenia,Obsessive/ Compulsive disorder | | | |
| Anxiety,depression | | | |
| Severe stress | | | |
| Eating Disorder | | | |
| Have you ever tried to harm yourself? | | | |
| **Eyesight** | **Yes** | **No** | **Details** |
| Eye disease, infection, inflammation, bleeding | | | |
| Glaucoma, disease of the retina | | | |
| Have you undergone any eye surgery? | | | |

| **Hearing** | **Yes** | **No** | **Details** |
|---|---|---|---|
| Are you aware of any hearing problems you might have? | | | |
| Non-infective ear-disorder(e.g. tinnitus,vertigo) | | | |
| Infective ear disease (e.g. discharge, glue ear) | | | |
| Hearing loss | | | |
| **Gastro-Intestinal/Abdominal** | **Yes** | **No** | **Details** |
| Hernia | | | |
| Any bowel problems(e.g. colitis, chronic diarrhoea, Irritable bowel Syndrome,Crohns | | | |
| Gall Stones, Pancreatitis | | | |
| Jaundice or Hepatitis A | | | |
| Kidney problems, Renal stones | | | |
| Chronic Indigestion,Stomach,Peptic or Duodenal ulcers | | | |
| Infections (e.g. Typhoid, Paratyphoid fever, Salmonella,Cholera) | | | |
| Recurring abdominal pains, gynaecological problems | | | |
| Severe problems with appetite or digestion | | | |
| Frequent need for the toilet or incontinence | | | |
| **Blood /Metabolic disorder** | **Yes** | **No** | **Details** |
| Any blood dis-order, disorder of lymph glands,anaemia,leukaemia | | | |
| Any congenital disorder manifested through the blood?(*If yes, please give details in a separate sheet*) | | | |

| | | | |
|---|---|---|---|
| Any disease carried through the blood(e.g. Hepatitis B) | | | |
| Thyroid, Pituitary, or hormone disorder | | | |
| Diabetes Mellitus *If yes, please indicate severity by ticking one of the following (mild, moderate, or severe)* | | | |
| **Neurological** | **Yes** | **No** | **Details** |
| Headaches, Cluster headaches, Migraines<br>*If yes, please tick severity (mild, moderate or severe and how often on the dotted line* ..... | | | |
| Severe head injury, fainting, loss of balance double vision, vertigo | | | |
| Epilepsy | | | |
| **General Medical** | **Yes** | **No** | **Details** |
| Cancer | | | |
| Malaria *(How often)* | | | |
| Other debilitating Illnesses *(If yes, please give details in a separate sheet)* | | | |
| Do you suffer any medical condition affecting your sleep? *(If yes, please give details in a separate sheet)* | | | |
| Have you ever had any medical condition not mentioned above that has involved your Doctor, a hospital, or specialist? *(If yes, please give details in a separate sheet)* | | | |
| Allergies *(If yes, please give details in a separate sheet)* | | | |
| Operations *(If yes, please give details in a separate sheet)* | | | |
| Are you currently taking any prescribed medication or receiving | | | |

| | | | |
|---|---|---|---|
| injections *(If yes, please specify type and time-table in a separate sheet)* | | | |

**I certify that I have answered all questions to the best of my ability and knowledge. This should be signed by parent if student is under 18.**

**Signed ……  Date ……**

**Write name in Capital letters ……**