Confidential Pupil Health Form

Child's Name Date of Birth	**Address** Phone number
GP Name Address Phone number	**Which clinic was your health visitor based in?** Health visitor name (if known)
Parent/Guardian Name Address Phone Home Work Mobile	**Parent/Guardian** Name Address Phone Home Work Mobile
Who holds parental responsibility?	

Additional emergency contact

Name

Relationship

Phone number Home

Mobile

Siblings

Name	Date of Birth	School/nursery
Name	Date of Birth	School/nursery
Name	Date of Birth	School/nursery

Has your child ever required treatment for

Condition	Details
Abdominal problems	
Anxiety	
Behavioural/Development problems	
Bleeding problems	
Bone/joint problems	
Breathing problems	
Convulsions/seizures – as an infant or later	
Diabetes	
Dietary intolerance	
Ear problems/deafness	
Eye problems (include if needs glasses)	
Faints/blackouts	
Frequent sore throats	
Growth/weight problems	
Hay Fever	
Headaches	
Heart problems	
Mental health problems	
Nasal obstructions/nose bleeds	
Skin conditions	
Thyroid problems	
Toileting difficulties eg. Urine infections, constipation, bedwetting	
Other (please give details)	

Were there any complications at your child's birth? Eg. premature, needing special care, etc.

If yes, please give details Yes ☐ No ☐

Has your child had any common childhood illnesses? Eg. chicken pox

If yes, please give details Yes ☐ No ☐

Has your child ever been admitted to hospital? Yes ☐ No ☐

If yes, please give details

Is your child currently seeing a GP or specialist for any medical concern? Yes ☐ No ☐

If yes, please give details

Is your child on any regular medication? Yes ☐ No ☐

(including creams, inhalers, homeopathic remedies, over the counter medicines, etc.)

If yes, please give details

Does your child have any allergies, including to medication? Yes ☐ No ☐

If yes

What are they allergic to?	Reaction	Treatment

Do they have an Epipen? Yes ☐ No ☐

Are there any concerns that you wish to speak to the school welfare officer about?

Immunisation History (Routine programme from January 2020)

Age normally given	Immunisation to protect against:	Vaccine Given	Tick if immunised
8 Weeks	5-in-1 vaccine (Diphtheria, Tetanus, Pertussis, Polio, Hib, Hepatitis B)	DTaP/IPV/Hib/HepB	
	Meningococcal group B (MenB)	MenB	
	Rotavirus gastroenteritis	Rotavirus	
Twelve Weeks	5-in-1 vaccine (Diphtheria, Tetanus, Pertussis, Polio, Hib, Hepatitis B)	DTaP/IPV/Hib/HepB	
	Pneumococcal	PCV	
	Rotavirus	Rotavirus	
Sixteen Weeks	5-in-1 vaccine (Diphtheria, Tetanus, Pertussis, Polio, Hib, Hepatitis B)	DTaP/IPV/Hib/HepB	
	MenB	MenB	
One year old (on or after the child's first birthday)	Pneumococcal disease	PCV Booster	
	Hib & MenC	Hib/MenC	
	Measles/mumps/rubella	MMR[2]	
	MenB	MenB	
3 years 4 months (or soon after)	Measles/mumps/rubella	MMR[2]	
	Diphtheria, Tetanus, Pertussis, Polio	DTaP/IPV	

Any other immunisations

Please give details

I declare the information on this form to be accurate and correct at the time of signing.

.....	.....	.....
Name (Printed)	**Signature**	**Date**

.....	.....	.....
Name (Printed)	**Signature**	**Date**

PTO

Parental consents

I/we understand that in an emergency every effort will be made to obtain my/our consent for emergency treatment, but if this proves impossible I hereby authorise Goodwyn School to act in loco parentis.

I/we confirm that I/we understand that the school may use discretion in disclosing information about my child to other professionals in order to protect the best interests of my child or another pupil in the school.

I/we hereby give consent for my child to participate in routine school health checks.

If my child needs medication at school, I/we agree to supply these promptly and to replace these before they expire. I will not allow my child to carry their own medication without prior agreement from teaching staff. I understand that my child may not be allowed to attend school if there is not appropriate medication in school.

I agree to keep the school updated about changes in my child's health.

.....	.....	.....
Name (Printed)	**Signature**	**Date**

.....	.....	.....
Name (Printed)	**Signature**	**Date**