Medical Information and Consent Form

The School requires you to complete all sections of this form as fully as possible. The information provided by you in this form will help us to care for your child while he / she is a pupil at the School.

All information received on this form will be treated in confidence.

For more information about how the School may use your and your child's information contained in this form, please see our privacy notice for pupils and our privacy notice for parents which were enclosed with the letter of offer and published on the School website: Policies | Kerem School.

Child's details

Child's full name:	
Date of birth:	

Child's doctor's details

Name of child's doctor:	
Address of child's doctor:	
Telephone number for child's doctor:	

Eyesight and hearing

Does your child have an eyesight condition? (please tick one box)	**Yes**		**No**	
Does your child have a hearing condition? (please tick one box)	**Yes**		**No**	
If you have answered Yes to either question above, please provide details below:				
If your child takes any medication for an eyesight or hearing condition, please provide details in the Medication section in this form.				

Infectious conditions

Has your child had any of the following infectious conditions? **(please indicate by ticking either Yes or No for each condition)**			
Condition:	**Yes**	**No**	**Approximate date of infection**
Mumps			
Rubella			
Chicken pox			
Measles			
Glandular fever			
Rheumatic fever			
If you have answered Yes to any of the above, please provide details below:			
Has your child been in contact with anyone with an infectious or contagious disease? **(if Yes, please provide details in the box below)**			

Allergies

Does your child have any allergies?				
Hay fever	**Yes**		**No**	
Medicine **(if Yes, please provide details in the box below)**	**Yes**		**No**	
Animals **(if Yes, please provide details in the box below)**	**Yes**		**No**	

Foods **(if Yes, please provide details in the box below)**	**Yes**		**No**	
Other allergies **(if Yes, please provide details in the box below)**	**Yes**		**No**	
If your child takes any medication for an allergy, or carries an Epi-pen or other auto-injector, please provide details in the Medication and treatment section in this form.				
If your child has special dietary requirements or preferences, please provide details in the box below:				
Whilst the school aims to understand a child's food preferences, these will only be accommodated in exceptional circumstances, following significant work with their Key Person and in partnership with home to develop the child's palate, and solely at the discretion of the Headteacher.				

Other conditions

Does your child have any of the following conditions?				
Asthma	**Yes**		**No**	
Diabetes - type 1	**Yes**		**No**	
Diabetes - type 2	**Yes**		**No**	
Epilepsy	**Yes**		**No**	
Mental health condition(s) **(if Yes, please provide details in the box below)**	**Yes**		**No**	

Other condition(s) **(if Yes, please provide details in the box below)**	**Yes**		**No**	
If your child takes any medication or receives treatment for an above named condition, please provide details in the Medication and treatment section in this form.				

Immunisation

The following table lists the routine and optional vaccinations (including travel vaccinations) available for children in the UK.

Please provide date(s) of immunisation of your child where indicated or, if immunisation not carried out, please state.

Immunisation	Date(s) of Immunisation
Routine vaccinations	
6 in 1 vaccine **(Diphtheria, tetanus, whooping cough, polio, hepatitis B, hib)**	
PCV **(Pneumococcal jab)**	
Rotavirus	
Men B **(Meningococcal type B)**	
Hib / Men C	
MMR **(Measles, mumps, rubella)**	
Children's 'flu vaccine	
4 in 1 Pre-school booster **(Diphtheria, tetanus, whooping cough, polio)**	
HPV	
3 in 1 teenage booster **(Diphtheria, tetanus, polio)**	

Meningitis **(Meningococcal types A, C, W, Y)**	
Optional vaccinations	
Chickenpox	
BCG **(Tuberculosis)**	
Influenza	
Coronavirus (COVID-19)	
Travel vaccinations	
Typhoid	
Cholera	
Yellow Fever	
Meningitis **(Meningococcal types A and C)**	
Hepatitis A	
Hepatitis B	
Japanese encephalitis	
Tick-borne encephalitis	
Rabies	
Other **(please provide details in the box below)**	

Medication and treatment

Name of medication / treatment	Reason for medication / treatment	Dosage **(if applicable)**	Frequency

Please provide details below of any condition which may prevent your child from taking a full part in the School's academic and games or sports curriculum, and outdoor activities.

I / We have provided full and complete information about my / our child in this Medical Information Form.

I / We agree to inform the School in the event that my / our child's health or needs change.

I / We also agree to inform the School of any medication or treatment my / our child is receiving as I / We understand that appropriately qualified School staff may administer medication or need to refer on to Medical, Dental and Optical specialists as required.

	First signatory	Second signatory
Signature		
Title **(e.g. Mr, Mrs, Ms)**		
Name in full **(please include all names)**		
Relationship to child		
Date		

Medical Consent

1 **First Aid:** I / We consent to appropriately trained and qualified members of the School staff administering first aid to my / our child where appropriate.

2 **Medical treatment:** I / We hereby give my / our consent for the School to act on my / our behalf as necessary for my / our child's welfare if he / she requires a medical examination, medical testing or minor medical treatment such as attendance at a local GP, Doctor or Optician.

3 **Emergency Medical Treatment:** I / We give my / our consent for the Head Teacher to act on my / our behalf to authorise emergency medical treatment as necessary for my / our child's welfare in the event I / we or second emergency contact cannot be contacted in time.

4 **The Administration of Medicines:** I / We give my / our consent for appropriately qualified members of the School staff to administer prescription medication as listed in the Medication Section of the Medication and Treatment section of the Medical Information Form or as subsequently notified to the School.

	First signatory	Second signatory
Signature		
Title **(e.g. Mr, Mrs, Ms)**		
Name in full **(please include all names)**		
Relationship to child		
Date		