WELCOME TO
SEVENOAKS SCHOOL
DAY PUPIL’S MEDICAL FORMS

Please complete the forms and return the completed pack to the Health Centre

Health Centre, Sevenoaks School, High Street, Sevenoaks, Kent, TN13 1HU

nxj@sevenoaksschool.org
Dear Parent,

As the Medical Officer for Sevenoaks School, I am writing you this letter to accompany the medical information form that must be completed in full for your son or daughter who will be joining us this August. I would like to provide you with information about the services we provide at the School Health Centre, as well as to stress the importance of the medical form that accompanies this letter.

All boarders at the school will be registered as National Health Service (NHS) patients with Amherst Medical Practice. When at school, they will be seen at the School Health Centre by myself, Dr Richard Tosh or Dr Esther Cheesman. However if they are seen by an NHS doctor from another practice in the holidays, they must register with that practice as a ‘Temporary Patient’ only.

As NHS patients, referrals can be made to secondary care services as required, either on the NHS or privately if it is thought to be clinically appropriate.

The School Nurse team provide extensive cover during the school day for advice and assessment of any medical concerns. They also run an out of hour’s telephone advice service.

Health Centre services include:
- School counsellors
- Physiotherapy (Private Service)
- Child health immunisation advice
- Travel health
- Sexual health
- General health advice
- Health education (PSHE programme)
- OPRO service offering custom made mouthguards

The attached medical forms are confidential and need to be completed in full and returned directly to me at the Sevenoaks School Health Centre.

The purpose of this form is for the medical and nursing staff to be made aware of any significant past history of medical or psychological problems, together with information about any medication currently being taken. This includes history of allergies and a record of previous immunisations.

All new boarders will have a standard basic medical examination at the beginning of the Michaelmas Term. This will include measurements of the pupil’s weight, height and blood pressure, as well as a brief eye examination and urine testing. Any pupil taking regular prescribed medication or has a chronic or acute illness will automatically be examined by myself or my colleagues. Pupils have an option to see a same gender GP.
As most Sevenoaks School pupils go on overseas trips during their time at the school, we would like a Hepatitis B vaccination course to have been completed before they arrive at the school.

All pupils should have had vaccines equivalent to the UK schedule of vaccinations before they start school. For information on this please search on this link: http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx

The information we receive from you will remain confidential and available only to the Health Centre Staff and will only be shared with relevant staff on ‘a need to know basis’ in the pupil’s best interest. It is imperative that you inform us at medical@sevenoaksschool.org of any changes in your child’s health during exects or holidays. This is particularly important if any medication is commenced whilst away from school. The school policy is to disclose the use of herbal remedies and food supplements because of the risk of interactions, the possibility of side effects and the poor quality control of some products. Any medicinal product brought into the school must be labelled correctly, in English, with the pupils name the medication name and directions on the packet.

It is essential that any medication prescribed outside of school is presented to the Health Centre staff so that they can check that it is licensed for use in the UK and that its use remains clinically indicated. Where necessary we will find the equivalent medication available in the UK.

If you have any concerns regarding the health of your son or daughter, we would like to hear from you. At the Health Centre we strive to ensure the optimal physical and mental wellbeing for your child and look forward to receiving their detailed medical information.

Yours faithfully

Dr Francoise Lyons
MBBS MRCGP DRCOG DFSRH
Sevenoaks School Medical Officer
GP Partner, Amherst Medical Practice
MEDICAL CONSENT FORM

Pupil’s Full Name: _______ (Block Capitals)

Please sign ALL the applicable sections in the appropriate places below. To reduce administration we ask that you sign this form to give consent during your child’s entire school career at Sevenoaks School. However it’s imperative that you inform the School Health Centre of any changes as they arise.

- **Consent to act on behalf of parents in the event of an emergency:**
  I give permission to the Head or designated representative to give consent to any dental, optical, medical or surgical treatment, including anaesthetic or blood transfusion required in an emergency by my child, if the School is unable to contact parents/guardians.

  Signed: ____________________________ Date: _______________

  Relationship to child: ____________________________

Please tick if your child has been prescribed: Adrenaline Auto Injector [ ] OR Inhaler [ ]

OR if your child has any significant medical condition requiring prescribed medication [ ]

- **Consent to use the School Emergency Inhaler:**
  I give consent to use the school emergency salbutamol inhaler in the event of my child displaying symptoms of asthma, and their own inhaler is not available or does not work.

  Signed: ____________________________ Date: _______________

  Relationship to child: ____________________________

- **Consent to use the School Adrenaline Auto Injector (AAI):**
  I give consent to use the school emergency AAI in the event of my child displaying symptoms of anaphylaxis, and their own AAI is not available or does not work.

  Signed: ____________________________ Date: _______________

  Relationship to child: ____________________________

- **Consent to Administer First Aid and Medication**
  I give consent for my child to receive first aid and/or medication from a qualified nurse or designated member of staff according to the School’s Medical protocol for the administration of drugs. This includes over the counter non-prescription medication, including the following: Paracetamol, Ibuprofen, Calpol 6+, Piriton, Loratadine, Dioralyte, Rennie, Imodium, Honey & Glycerine Syrup, Throat Lozenges, Sudafed, Olbas Oil, Anthisan, Arnica Cream, and Kwells (for travel sickness).

  Please state if any of the above over the counter medication cannot be taken due to allergies:

  ____________________________

  Signed: ____________________________ Date: _______________

  Relationship to child: ____________________________
THIS FORM SHOULD BE RETURNED TO THE HEALTH CENTRE BY EMAIL WITHIN 2 WEEKS OF RECEIPT

Pupil’s Surname: ____________________________

Pupil’s First Name(s): ____________________________

Date of Birth: ____________________________

Home Address: ____________________________

__________________________________________________________________________

__________________________________________________________________________

Please insert a photo of the pupil above

CONTACT DETAILS

Mother:

Full Name: ____________________________ Mobile: ____________________________

Home Tel No: ____________________________ Work Tel No: ____________________________

Email: ____________________________

__________________________________________________________________________

Father:

Full Name: ____________________________ Mobile: ____________________________

Home Tel No: ____________________________ Work Tel No: ____________________________

Email: ____________________________

__________________________________________________________________________

GP’s Name, Address and Phone Number:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
# Important Medical Information

Pupil’s Full Name: __________________________

Please give details if your child suffers with any food intolerances, allergies (including medicines), or has any dietary requirements.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Does your child carry a prescribed inhaler for Asthma?</td>
<td></td>
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<tr>
<td>Has or is your child being seen by a GP, Specialist or Therapist?</td>
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<tr>
<td>Has your child been admitted to hospital for treatment or investigation?</td>
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<tr>
<td>Does your child need to carry an injectable adrenaline pen such as an epipen, jextpen or emerade?</td>
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<tr>
<td>Does your child suffer from Diabetes, Epilepsy or any significant neurological condition?</td>
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<td>Has your child ever had concussion?</td>
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<tr>
<td>Has or is your child receiving treatment or medication from a Psychologist or Psychiatrist?</td>
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<tr>
<td>Is your child taking treatment for ADHD?</td>
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<tr>
<td>If yes, we will need the latest clinic letter from their supervising specialist.</td>
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</tbody>
</table>

Please give FULL details if you answer YES to any of the above questions. Use a separate sheet if necessary, STATING CLEARLY ANY PRESCRIBED OR OVER THE COUNTER MEDICATION.

Has your child ever suffered from or had treatment for:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If yes, please give details (use a separate sheet if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eczema</td>
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<tr>
<td>Hay Fever</td>
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<td>Nose/Throat problems</td>
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<td>Deafness</td>
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<tr>
<td>Bone or Joint Disease</td>
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<tr>
<td>Defective eyesight</td>
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<tr>
<td>Headaches or Migraines</td>
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</tbody>
</table>

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**This page is confidential and only shared on 'a need to know basis' at the discretion of the School Medical Officers**
# Immunisation History

Pupil’s Full Name: ____________________________________________

Please complete the following immunisation dates. You will need to provide scanned evidence of all vaccinations given to date.

**Confirmation of up to date immunisations as per the UK routine immunisation schedule:**

- I confirm that my child has received all vaccinations necessary for the UK as country of residence.
- I confirm that I will keep you informed and provide evidence of any vaccinations given during my child’s time at school e.g. during holidays or exeat weekends.

Please see the following link to check that your child is up to date with the UK routine immunisation schedule: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699392/complete_immunisation_schedule_april2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699392/complete_immunisation_schedule_april2018.pdf)

**Signed:** ________________________________  **Date:** ______________________________

**Relationship to child:** ________________________________

<table>
<thead>
<tr>
<th>Routine</th>
<th>1st Dose</th>
<th>2nd Dose</th>
<th>3rd Dose</th>
<th>Latest Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria</td>
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<tr>
<td>Tetanus</td>
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<td>Polio</td>
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<td>Whooping Cough</td>
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<td>Hib</td>
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<tr>
<td>Meningitis C</td>
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<td>HPV</td>
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<tr>
<td>Influenza</td>
<td>Date of last dose:</td>
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<table>
<thead>
<tr>
<th>Travel</th>
<th>1st Dose</th>
<th>2nd Dose</th>
<th>3rd Dose</th>
<th>Latest Booster</th>
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<tbody>
<tr>
<td>Hepatitis B</td>
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<tr>
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<td>Typhoid</td>
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<td>Yellow Fever</td>
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<td>BCG</td>
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**Other (please specify)**

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www.sevenoaksschool.org  nrxj@sevenoaksschool.org
Additional Information