SEDBERGH SCHOOL PUPIL MEDICAL INFORMATION

PLEASE RETURN TO: THE REGISTRAR, SEDBERGH SCHOOL, SEDBERGH, CUMBRIA LA10 5HG
or via admissions@sedberghschool.org

STATEMENT OF PREVIOUS HEALTH TO BE COMPLETED FOR ALL PUPILS	
Pupil's name in full:	
School:	☐ Casterton, Sedbergh Preparatory School ☐ Sedbergh Senior School
Boarding House Name:	
Boarder / Flexi-Boarder / Day Pupil:	☐ Full Boarding ☐ Flexi Boarding ☐ Day Pupil
Number of terms:	☐ Full Time ☐ 3 Terms ☐ 2 Terms ☐ 1 Term
Date of birth (DD/MM/YYYY):	
Start date at School (DD/MM/YYYY):	
Entry Year Group:	☐ Nursery ☐Reception ☐Y1 ☐Y2 ☐Y3 ☐Y4 ☐Y5 ☐Y6 ☐Y7 ☐Y8 ☐Y9 ☐Y10 ☐Y11 ☐Y12 ☐Y13
Town and Country of Birth:	
Ethnic Origin:	White:British/Irish/Other(Specify): ☐…….. Asian / Mixed (Specify) ☐…….. Chinese ☐ African ☐ Other (specify) ☐……
Main spoken language:	
Name and address of previous Registered GP: (If currently at Boarding School please give name of School and School GP)	
NHS number (if applicable)**:** On medical card or available from your GP	

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PARENT DETAILS	
Name:	
Home Address:	
Tel No:	
Mobile:	
Fax:	
Email Address: By entering an email address you are consenting to medical information (the minimum required regarding your child) being sent to you via the internet - with no 100% guarantee of confidentiality. **Authorising Signature for Emails:**	
Who do these contact details belong to? e.g. Mother, Father, Guardian, other	
Can we leave messages regarding your child on these numbers?	**YES** ☐ **NO** ☐
Who else lives in this household? Please carefully tick all that apply	Mother ☐ Father ☐ Step parent ☐ Parent's Partner ☐ Grandparents ☐ Brothers & Sisters (how many) ☐ …….. Foster carer ☐ Guardian ☐ Other (please state):……
Who has parental responsibility for this child?	Name: Contact Details: Relationship:
Has your child ever been under a Child Protection Plan?	**YES** ☐ **NO** ☐
Does your child have any contact with any of the following?	A hospital specialist: **YES** ☐ **NO** ☐ A Health Visitor: **YES** ☐ **NO** ☐ A social worker: **YES** ☐ **NO** ☐ Any other health care professional: **YES** ☐ **NO** ☐ Please specify:
Signature of Parent/Guardian:	
Date:	

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IF YOUR CHILD IS OVER 16 THEY MUST COMPLETE AND SIGN BELOW TO ALLOW US TO DISCUSS THEIR MEDICAL RECORD WITH THEIR NEXT OF KIN WHEN APPROPRIATE:

Can we discuss your medical record with your next of kin / guardian?	**YES** ☐ **NO** ☐
Signature of pupil:	
Date:	

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

- I understand that I may need to pay for NHS treatment outside of the GP practice ☐
- I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested ☐
- I do not know my chargeable status ☐

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	
Print Name:		Relationship to patient:	
On behalf of:			

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Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	**YES:** **NO:**	If yes, please enter details from your EHIC or PRC below:
 *If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital*	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD/MM/YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD/MM/YYYY
PRC validity period	From: DD/MM/YYYY	To: DD/MM/YYYY

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff .

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

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TO BE COMPLETED FOR ALL PUPILS

1. Allergies

Please list any allergies to medication, food or other substances experienced by your child (i.e., has developed swelling or a rash).

2. Ongoing Medical Problems

Please record any important medical problems affecting your child (e.g., Diabetes, Asthma, Eczema, Heart conditions, Epilepsy). When necessary we will complete a health care plan, which will be sent to you for comment and signature.

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3. Medication

Please give a list of your child's current prescription medication

4. Family History

Please record any significant family history including:

a) Any history of sudden death in young adults
b) Any history of heart disease in family members under the age of 60
c) Any other history, which you may feel, is relevant and important (e.g., Diabetes, Asthma, Cancer of the Colon, Breast Cancer).

5. Any Other Health concerns / problems

e.g., eye sight, teeth, bed wetting etc.

6. Health Insurance

Please indicate your preference below:

NHS exclusively ☐
NHS + own personal Scheme ☐

7. Immunisation Record

IMMUNISATION	DATES GIVEN
Diptheria, tetanus, pertussis, polio, Hib	1
	2
	3
	4
	5
Meningitis ACWY	1
	2
	3
MMR (Mumps, Measles, Rubella)	1
	2
TB (BCG)	1
HPV (Girls Only)	1
	2
	3
Additional Immunisations:	

By signing and returning a scanned copy of your signed form to us you are confirming that you wish to be bound by its contents

Signature of Parent/Guardian:

Date:

CONSENT TO OPERATION

TO BE COMPLETED FOR ALL PUPILS

Should your child need surgery, we will make every effort to get in touch with you beforehand. If your child is aged 16 they can consent to treatment themselves, however there may be occasions (for example, acute Appendicitis) where time is of the essence and for those cases, we would be grateful if you could sign the consent form below:

I, (name of Parent or Guardian)	
of (permanent address)	
hereby give consent to my son/ daughter/ ward (full name)	
to undergo any operation which may be deemed necessary during periods of residence at Sedbergh School and for the administration of a general or local anaesthetic for that purpose.	
Signature of Parent or Guardian:	
Date:	

OR, IF NOT WISHING TO CONSENT

I do NOT give my Consent to Operation:	Please tick ☐
Signed:	
Date:	
PRINT NAME:	

CONSENT TO MEDICATION

TO BE COMPLETED FOR ALL PUPILS

Guidelines are issued to the House Staff regarding the dispensing of over the counter remedies, such as Paracetamol and Anti-histamines. If you are happy for your child to receive these treatments, please sign below and/or record any specific objections:

I, (Name of Parent or Guardian)	
of (permanent address)	
hereby give consent to my son/daughter/ward (full name)	
to receive over the counter remedies.	
Signature of Parent or Guardian:	
Date:	

OR, IF NOT WISHING TO CONSENT

I do NOT give my Consent to Medication:	Please tick ☐
Signed:	
Date:	
PRINT NAME:	

Please note that this would mean your child would not be given Paracetamol or anti-histamines if required. However, if your chld is 16 years old or over, they can self-consent.

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Please note the consent below is only necessary and valid if your child is under the age of 16 as per the guidance which can be accessed at: http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp

Please make any objections you have to vaccination clear to your child as we endeavour to ensure all pupils are fully vaccinated before they leave school

CONSENT TO VACCINATION

MUST BE COMPLETED FOR ALL BOARDERS & FLEXI BOARDERS – MAY ALSO BE FOR DAY PUPILS

We offer routine childhood vaccinations as per the NHS recommended schedule (which changes from time to time). We also offer travel vaccinations when needed for specific foreign destinations. If you wish your child to receive the standard immunisations, please sign below. Please record any specific objections.

You may withdraw your consent at any stage in writing.

I, (Name of Parent or Guardian)	
of (permanent address)	
hereby give consent to my son/daughter/ward (full name)	
to receive immunisations recommended by national guidelines and if necessary for foreign travel.	
Signature of Parent or Guardian:	
Date:	

OR, IF NOT WISHING TO CONSENT

I do NOT give my Consent to Vaccination:	Please tick ☐
Signed:	
Date:	
PRINT NAME:	

CONSENT TO INFLUENZA VACCINATION

TO BE COMPLETED FOR ALL PUPILS

- I would like my child to receive an annual influenza vaccination and agree to a small charge being applied unless they are in an "at risk" group and will be covered by the NHS.

I, (Name of Parent or Guardian)	
of (permanent address)	
hereby give consent to my son/daughter/ward (full name)	

Signature of Parent or Guardian:	
Date:	

OR, IF NOT WISHING TO CONSENT

I do NOT give my Consent to Influenza Vaccination:	Please tick ☐
Signed:	
Date:	
PRINT NAME:	

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CONSENT FOR SUMMARY CARE RECORD TO BE COMPLETED FOR ALL PUPILS AGED 16 & OVER	
I	
of (permanent address)	
hereby give consent to (full name of pupil)	
Summary Care Record ☐ Express consent to medication, allergies and adverse reactions only ☐ Express dissent (opted out) Patient does not want a Summary Care Record. **Local Shared Record** ☐ Patient consents to sharing the detailed record ☐ Patient does not wish to share the detailed record	
Signature of Pupil:	
Date:	

Summary Care Record:
A Summary Care Record is automatically created for children up to the age of 15 years and 9 months, as their consent is not required. If a child's parent/guardian does not wish the child to have a summary care record they must discuss this with their child's GP, but ultimately it is the GP's decision, because of their duty of care to the child.

The Summary Care Record is meant to help emergency doctors and nurses help you when you contact them when the surgery is closed. Initially, it will contain just your medications and allergies.

As the central NHS computer system develops, (known as the 'Summary Care Record' - SCR), other staff who work in the NHS will be able to access it along with information from hospitals, out of hours services, and specialists letters that may be added as well.

Your information will be extracted from practices such as ours and held on central NHS databases.

Local Shared Record:
Health Services in South Lakeland now have the ability to share some information from your medical records with other health services that provide you with care. This information is limited, is called a local shared record and is not linked to the national system, (Summary Care Record). It does not copy details and file them in a national database, rather making a view available if needed with your consent at some point in the future.

Only healthcare professionals directly involved with your care can see your shared record and only at the time they are treating you. This may include Cumbria health on-call (CHOC), Accident and Emergency departments, community nurses and physiotherapists.