



# SEDBERGH SCHOOL PUPIL MEDICAL INFORMATION

**Sedbergh Prep School**  
**RECEPTION – YEAR 8 PLEASE RETURN TO: THE REGISTRAR,**  
**SEDBERGH PREP SCHOOL, CASTERTON, NR KIRKBY**  
**LONSDALE, CUMBRIA LA6 2SG or via**  
**[admissions@sedberghprep.org](mailto:admissions@sedberghprep.org)**

**Sedbergh Senior School**  
**YEARS 9 – 13 PLEASE RETURN TO: THE REGISTRAR,**  
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**or via [admissions@sedberghschool.org](mailto:admissions@sedberghschool.org)**

## STATEMENT OF PREVIOUS HEALTH

TO BE COMPLETED FOR ALL PUPILS

<b>Pupil's name in full:</b> BLOCK CAPITALS PLEASE	Surname
	First name(s)
<b>Date of birth (DD/MM/YYYY):</b>	
<b>NHS number (if applicable):</b> On medical card or available from your GP	
<b>Town and Country of Birth:</b>	
<b>Name and address of previous Registered GP:</b> If currently at Boarding School, please give name of School and School GP	
<b>School (please tick):</b>	<input type="checkbox"/> Casterton, Sedbergh Preparatory School <input type="checkbox"/> Sedbergh Senior School
<b>Boarding House Name:</b>	
<b>Boarder / Flexi-Boarder / Day Pupil:</b>	<input type="checkbox"/> Full Boarding <input type="checkbox"/> Weekly (CSPS) <input type="checkbox"/> Tri Boarder (CSPS) <input type="checkbox"/> Day Pupil
<b>Number of terms:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> 3 Terms <input type="checkbox"/> 2 Terms <input type="checkbox"/> 1 Term
<b>Start date at School (DD/MM/YYYY):</b>	
<b>Entry Year Group:</b>	<input type="checkbox"/> Nursery <input type="checkbox"/> Reception <input type="checkbox"/> Y1 <input type="checkbox"/> Yr2 <input type="checkbox"/> Yr3 <input type="checkbox"/> Yr4 <input type="checkbox"/> Yr5 <input type="checkbox"/> Yr6 <input type="checkbox"/> Yr7 <input type="checkbox"/> Yr8 <input type="checkbox"/> Yr9 <input type="checkbox"/> Yr10 <input type="checkbox"/> Yr11 <input type="checkbox"/> Yr12 <input type="checkbox"/> Yr13
<b>Ethnic Origin:</b>	White/British/Irish/Other (specify): <input type="checkbox"/> _____ Asian/Mixed (specify): <input type="checkbox"/> _____ Chinese <input type="checkbox"/> African <input type="checkbox"/> Other(specify): <input type="checkbox"/> _____
<b>Main spoken language:</b>	

We may process your personal information for carefully considered and specific purposes which are in our interests and enable us to enhance the services or information we provide. We will always keep your details safe and secure. 'We' includes Sedbergh School, the charity, its charitable and all trading subsidiaries.

Our Privacy Notices can be found on our website (<http://www.sedberghschool.org/senior/Privacy-Policies>) or by request from The Deputy Bursar (Compliance), Sedbergh school, Malim Lodge, Sedbergh LA10 5RY. ([tr@sedberghschool.org](mailto:tr@sedberghschool.org)) If you have any concerns about the data we hold or do not wish to receive any further communications from us, please contact The Deputy Bursar (Compliance).

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PARENT DETAILS	
<b>Parent Name:</b>	
<b>Home Address:</b>	
<b>Tel No:</b>	
<b>Mobile:</b>	
<b>Email Address:</b> 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.	
<b>Authorising Signature for Emails:</b>	
<b>Who do these contact details belong to?</b> e.g., Mother, Father, Guardian, other	
<b>Who else lives in this household?</b> Please carefully tick all that apply	Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Parent's partner <input type="checkbox"/>  Grandparents <input type="checkbox"/> Brothers & Sisters (how many) <input type="checkbox"/> .....  Foster carer <input type="checkbox"/> Guardian <input type="checkbox"/> Other (please state) .....
<b>Who has parental responsibility for this child?</b>	Name:  Contact details:  Relationship:
<b>Has your child ever been under a Child Protection Plan?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Does your child have any contact with any of the following?</b>	A hospital specialist:                          YES <input type="checkbox"/> NO <input type="checkbox"/> A health visitor:    YES <input type="checkbox"/> NO <input type="checkbox"/> A social worker:    YES <input type="checkbox"/> NO <input type="checkbox"/> Any other healthcare professional:              YES <input type="checkbox"/> NO <input type="checkbox"/> Please specify: .....
<b>Signature of Parent/Guardian:</b>	
<b>Date:</b>	

**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:**



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## TO BE COMPLETED FOR ALL PUPILS (all 6 sections)

### 1. Ongoing Medical Problems

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

No known medical issues:

Details of medical issues:

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### 2. Allergies

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

No known allergies:

Details of allergies and care:

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### 3. Medication

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

No known medication:

Details of medication:

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## 4. Communication

Does your child have any communication needs relating to a disability, impairment or sensory loss?

NO

YES

Further details:

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## 5. Family History

Please record any significant family history such as sudden death in young adults / heart disease / asthma / cancer

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## 6. Any other health concerns / problems

e.g., eyesight, teeth, bed wetting etc

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## 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, (PRINT name of Parent or Guardian)**

**of (permanent address)**

**hereby give consent for my son/daughter/ward  
(full name of pupil):**

**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:**



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## CONSENT TO MEDICATION TO BE COMPLETED FOR ALL PUPILS

Guidelines are issued to the House4 Staff regarding the dispensing of over-the-counter remedies, such as paracetamol and antihistamines. If you are happy for your child to receive these treatments, please sign below and/or record any specific objections:

**I, (PRINT name of Parent or Guardian)**

**of (permanent address)**

**hereby give consent for my son/daughter/ward  
(full name of pupil):**

**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 antihistamines if required. However, if your child is 16-years old or over, they can self-consent.**



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## CONSENT TO PRIVATE NON-NHS INFLUENZA VACCINATION TO BE COMPLETED FOR ALL PUPILS

Please note: Pupils in reception to year 6 and pupils considered to be at risk will receive a free NHS nasal flu vaccine. Separate consent forms will be sent for that.

All other pupils will be offered annual influenza vaccination injection for a small charge. Please sign this consent form if you wish your child to receive that. Pupils over the age of 16 years of age can self-consent.

**I, (PRINT name of Parent or Guardian)**

**of (permanent address)**

**hereby give consent for my son/daughter/ward  
(full name of pupil):**

**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 Influenza  
Vaccination:**

Please tick

**Signed:**

**Date:**

**PRINT NAME:**



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## IMMUNISATION RECORD - THIS MUST BE COMPLETED WITH FULL DETAILS FOR ALL PUPILS

IMMUNISATION	DATES GIVEN DD/MM/YYYY
Diphtheria, tetanus, pertussis, polio, Hib	1
	2
	3
	4
	5
Meningitis C	1
	2
	3
Meningitis ACWY (this is not the same as Meningitis C)	1
MMR (Mumps, Measles, Rubella)	1
	2
TB (BCG)	1
HPV	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:** \_\_\_\_\_





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<b>CONSENT FOR SUMMARY CARE RECORD</b> TO BE COMPLETED FOR <u>ALL PUPILS AGED 16 &amp; OVER</u>	
<b>I, (PRINT name of Parent or Guardian)</b>	
<b>of (permanent address)</b>	
<b>hereby give consent for my son/daughter/ward (full name of pupil):</b>	
<p><b>Summary Care Record</b></p> <p><input type="checkbox"/> Express consent to medication, allergies and adverse reactions only</p> <p><input type="checkbox"/> Express dissent (opted out) Patient does not want a Summary Care Record</p> <p><b>Local Shared Record</b></p> <p><input type="checkbox"/> Patient consents to sharing the detailed record</p> <p><input type="checkbox"/> Patient does not wish to share the detailed record</p>	
<b>Signature of Pupil:</b>	
<b>Date:</b>	

### 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.