Columbus School & College
Find your remarkable

MEDICAL AGREEMENT FORM

(To be completed for all pupils/young people)

OVERVIEW: Under the General Data Protection Regulation (GDPR) and Data Protection Act 2018, there are a number of consents which we need to obtain from either you as the parent/carer or, **where appropriate**, the learner themself (over 13 years old). These consents remain in force for the entire time that your child is at the Academy unless you make written reference to the contrary. In some instances the consent relates to a more specific Academy policy, details of which are shown next to the heading. Parents/Carers are advised to read the relevant Policy which is available on the Academy website.

Student Name:		
Date of Birth:	**Weight:**	
Medical diagnosis / condition(s)	…… …… …… …… ……	
NHS Number:		

GP Contact Details	
Doctor's Name:	
Surgery Address:	…… …… ……
Telephone number:	

Hospital Contact Details		
Doctor/Consultant Name (if applicable):		
Hospital:		
Address:	…… …… ……	
Telephone number:		
Email Address:		
Does your child have direct access to hospital? (Yellow Card Holder) Please tick	**Yes**	**No**

Pupil Name: _____ **Date of Birth:** _____

I give permission for Columbus to pass information about my child to Broomfield Hospital. Should there ever be an emergency whereby we need to take your child to hospital, or if there is an appointment that you wish us to attend with you (where your child will also be present), this will give professionals working at the hospital a fuller understanding of the support requirements of your child. See attached letter for more information.	Yes	No

Does you child/young person have a diagnosis of Epilepsy?:	Yes	No
JEC care plan with rescue Medication	Yes	No
JEC Management Care Plan - No rescue Medication	Yes	No
Brief description of seizures:		
…… …… ……		

Does your child/young person require Enteral Feeding?	Yes	No
Type of Gastrostomy: (Please state)		
Size of Tube:		
Brand of Milk:		

Does your child/young person require Mouth/Nasal Suction?	Yes	No
Type of Suction Machine:		

Does your child/young person require Oxygen?	Yes	No

Does your child/young person have a diagnosis of Anapylaxis?	Yes	No
Please state allergen:		

Allergies – please give details and/or intolerances.
…… …… ……

Does you child/young person require any other Medical Intervention	Yes	No	
Please State:			

Medication – please give details of all medication administered both in and out of school					
Drug		Dose		Time	
Drug		Dose		Time	
Drug		Dose		Time	
Drug		Dose		Time	
Drug		Dose		Time	

Pupil Name: _____ Date of Birth: _____

Drug		**Dose**		**Time**	
Drug		**Dose**		**Time**	
Drug		**Dose**		**Time**	
Drug		**Dose**		**Time**	
Drug		**Dose**		**Time**	
Drug		**Dose**		**Time**	

All medication sent into school must have been checked to ensure that it is not out of date. It must have a clear label on the bottle or box from the pharmacy stating your child's name and required dose; **without this we will be unable to administer.**

If your child is prescribed a course of antibiotics, they must not return to school for 24 hours from the first administration of antibiotics. Following this, antibiotics can then be sent into school for administration, with clear guidelines and medication labelled as per instructions.

I give permission for prescribed daily, short-term and/or rescue medication to be administered in school where necessary.

Please tick one of the following boxes:	**Yes**	**No**

I give permission for any non-prescribed medication sent in from home to be administered in school when necessary. Please note: written permission is required on the first day that medication is to be administered in school.		
Please tick one of the following boxes:	**Yes**	**No**

Are immunisations up to date?	**Yes**	**No**	**Please indicate outstanding immunisations:**
……			
……			

Diet – please include likes, dislikes, sensory aversion, difficulties with textures, swallowing difficulties and general advice. Please refer to food AND drink.
……
……
……

I give permission for my child:		
To be weighed and height measured as appropriate	**Yes**	**No**
To be screened by the school nurse for basic health e.g. hearing, sight, weight etc.	**Yes**	**No**
To be given an appropriate dosage of Paracetamol/Calpol for minor ailments e.g. headaches, period pains	**Yes**	**No**
To have basic first aid i.e. plasters	**Yes**	**No**
To have sunscreen applied when necessary	**Yes**	**No**
To take part in aromatherapy and massage	**Yes**	**No**

Pupil Name: _____ Date of Birth: _____

Allergens	Please tick
My child is not allergic to any of the items listed below	
My child has been medically diagnosed and <u>is</u> allergic to the items ticked below. I will obtain and send in a letter from my GP confirming this.	
Peanuts	
Tree Nuts	
Eggs	
Sesame	
Soya	
Gluten	
Milk	
Celery	
Mustard	
Fish	
Crustacea	
Molluscs	
Sulphites	
Lupin	

COLUMBUS SCHOOL AND COLLEGE ARE NUT-FREE AND LATEX-FREE ZONES

Please note that Columbus School and Columbus College sites are both nut-free and latex-free zones.

Please may I, therefore, politely request that your child or young person does not bring in any form of nut or latex product into the School or College (for example balloons, loom bands, latex gloves or Nutella to mention a few.

We have a number of pupils and students who attend Columbus who have a latex and/or nut allergy which is the reason we need to impose this ban.

I confirm that the information I have provided within this medical agreement form is up to date and correct. I agree to contact the school as soon as any information changes so that appropriate paperwork and care can be adjusted accordingly.

PRINT NAME:……

Signed:……**Parent/Carer** **Date:**……

For office use only:

CW Emailed:		Approval received:		Entered on Arbor:	

Pupil Name: _____ Date of Birth: _____