

SENIOR BOARDING

Adams' Grammar School

Newport, Shropshire

MEDICAL RECORD (PRIVATE AND CONFIDENTIAL)

FULL NAME.....

NAME BY WHICH YOUR SON PREFERS TO BE CALLED

HOME ADDRESS

.....

.....

DATE OF BIRTH..... BLOOD GROUP (if known).....

FATHER'S NAME..... MOTHER'S NAME

FATHER' ADDRESS.....MOTHER'S ADDRESS.....

.....

.....

TEL NO. Home:..... TEL NO. Home:.....

Work:..... Work:.....

Mobile:..... Mobile:.....

E-mail..... E-mail.....

Name, Address & Telephone numbers of Appointed Guardians who may collect at exeat.
Please include status e.g. Guardian, Grandparent, Friend (List more than one if appropriate)

1).....

2).....

3).....

MEDICAL INFORMATION

CURRENT DOCTOR'S NAME & ADDRESS

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ALLERGIES (including details of reactions).....

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P.T.O.

Senior Boarding Medical Form

DETAILS OF ANY OPERATIONS (include dates)

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DETAILS OF CURRENT MEDICAL OR DENTAL REQUIREMENTS (Including any ongoing medication)

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ANY GENERAL INFORMATION, WHICH WILL HELP US IN CARING FOR YOUR SON

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Other IMMUNIZATIONS OR ILLNESS ~ Please fill in dates

TETNUS..... BCG / TUBERCULOSIS

DIPHTHERIA..... CHICKEN POX

MEASLES..... RUBELLA / GERMAN MEASLES

POLIO..... MUMPS.....

PERTUSSIS / WHOOPING COUGH MENINGITIS.....

We may be able to arrange for your son to visit the Dentist and Optician locally. However, we find that many parents do prefer to use their family practitioners. Please clearly specify:

Dentist	YES I agree to a school Dentist	NO I shall make home arrangements
Optician	YES I agree to a school Optician	NO I shall make home arrangements

Any other medical information, which you feel we should know for example childhood ailments still affecting your child. (Continue on a separate sheet if necessary)

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CONSENT FORM

I consent to my son receiving medical or surgical treatment including an operation (if necessary) from a qualified medical practitioner, or first aid from a qualified first aider, if an emergency should occur at a time when my consent cannot be obtained. I understand and accept that this may involve the use of an anaesthetic by a medically qualified person.

Signed Date

(Parent/Legal Guardian)

NAME (BLOCK CAPITALS)

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