ALLERGIES	MEDICAL ALERT	ATTACH PHOTO

BANDON GRAMMAR SCHOOL

MEDICAL RECORD
PRIVATE AND CONFIDENTIAL

STUDENT'S FULL NAME:

DATE OF BIRTH:

DATE OF ENTRY TO BANDON GRAMMAR SCHOOL:

DAY PUPIL 5 DAY BOARDER 7 DAY BOARDER please circle

PLEASE COMPLETE THIS MEDICAL FORM PRIOR TO COMMENCEMENT AND RETURN IT TO:
Admissions Office.
Bandon Grammar School,
Bandon,
Co. Cork
P72 FD36
Failure to do so will cause delay in commencing school

PARENT(S)/GUARDIAN(S) NAMES	NEXT OF KIN
Mother **ADDRESS**	**Father** **ADDRESS**

LANDLINE	SKYPE ID	GP/FAMILY DOCTOR DETAILS
MOTHER'S MOBILE	FATHER'S MOBILE	STUDENT'S MOBILE
MOTHER'S EMAIL	FATHER'S EMAIL	STUDENT'S EMAIL

IF NEXT OF KIN IS NOT RESIDENT IN IRELAND PLEASE GIVE DETAILS OF GUARDIAN/EMERGENCY CONTACT

NAME OF GUARDIAN:	ADDRESS:
RELATIONSHIP:	LANDLINE:
MOBILE:	EMAIL:
In order for the Medical Team at Bandon Grammar School to provide your child with the optimum care, please read the following and provide accurate information when requested. If you have any queries or wish to discuss Medical issues with our staff please contact our Registered Nurses Laura Gibbs or Sinead Riome at Bandon Grammar School Medical Room 00353(0)23 8844337 email:schoolnurse@bgsmail.ie	

MEDICAL HISTORY

PRIVATE AND CONFIDENTIAL

Please complete this section fully by ticking the appropriate box below and give details if answer is yes
Is your child on long term medication yes no If Yes please specify below-

Has your child ever had…..?	**Yes**	**No**	**Date**
A diagnosis of Asthma- If yes have they ever been admitted to hospital with their asthma and do you know their peak flow. Please complete the Asthma Control Test print it and attach to this form. https://www.asthmacontroltest.com/Europe/Ireland/en/adult			
A diagnosis of Epilepsy			
A diagnosis of Diabetes			

If you answered yes to any of the above questions please include a written management and treatment plan from the pupil's current healthcare provider with the completed medical form. Please also include written instructions and prescribed medication from their GP/Consultant if they might require emergency treatment such as Epipen's/ Glucagen/Midazolam. Please ensure all Emergency medication is in date, has been labelled with the child's name, D.O.B and dose, time and route of administration.

Has your child ever had?	**YES**	**NO**	**DATE (if yes)**
A Blood disorder or a clotting disorder.			
Congenital/Acquired Heart disease			
Respiratory issues other than Asthma.			

Ear, nose, throat problems			
Bone/ Joint problems			
Kidney Disease			
Enuresis (Bedwetting)			
Congenital/ Genetic condition			

If you answered yes to any of the above kindly provide any important relevant information below.

Has your child ever had any of the following infections?

INFECTIOUS DISEASES	**YES**	**NO**
Measles		
Mumps		
Rubella (German Measles)		
Chickenpox		
Tuberculosis (TB)		
Glandular fever (Mononucleosis)		
Whooping Cough		
Hepatitis A		
Pneumonia		
Meningococcal C		
Hepatitis B		
Other		

	YES	**NO**
Has your child ever been hospitalised?		
Has your child ever had surgery?		

Please give details and approximate dates of hospitalisation/surgery

DENTAL INFORMATION

Does your child have?	YES	NO
Braces		
Implant		
Problems with wisdom teeth		
Other –please provide details here		

IMMUNISATIONS

Vaccine	Date given	Booster due
BCG		
DPT (Diphtheria, Pertussis and Tetanus)		
Tetanus		
HIB		
Measles, Mumps, Rubella		
Polio		
Pneumococcal		
Hepatitis B		
Varicella (Chickenpox)		
HPV		
Meningitis C		
Meningitis B		

COUNSELLING AND MENTAL HEALTH

Please note that medical and/or mental health conditions that may impact on your child's education, or ability to cope with boarding or on school safety **MUST** be disclosed.

Has your child ever?	Yes	No
Suffered from anxiety and/or depression		
Required or is currently having counselling/psychotherapy/treatment		
Attempted self- harm		
Been diagnosed with a specific learning difficulty(SLD) e.g., Dyslexia, ADHD, Asperger's Syndrome, Autism etc.		

Has or is currently taking medication for the treatment of anxiety, depression or an SLD		
Been bullied or being bullied		
Has issues surrounding eating or a tendency or diagnosis of an eating disorder		
Emotional issues/ low mood/ low self esteem		
I the answer is yes to any of the above questions please provide any important information below. Matters concerning pupil mental health are dealt with by the Nursing and Pastoral care team with the greatest of sensitivity and confidentiality.		

ALLERGIES AND/OR FOOD INTOLERANCES

Does your child have…..?	**YES**	**NO**
A food intolerance		
A food allergy		
Require an Epipen/Anapen		
An allergy to any medication		

If the answer is yes to any of the above please provide details of symptoms of the intolerance/allergy and include a written, signed prescription and instructions for emergency medication administration. If your child requires emergency medication at school please send it in with them on the first day of school - please ensure it is labelled with name, D.O.B, route of administration, dose and expiry date. It will be stored in the Medical room. Use additional page if needed.

MEDICAL CARD/ INSURANCE DETAILS

Name of Insurer Phone number of Insurer	
Policy Number/Medical Card number	
We advise all parents of European and International students to have appropriate private medical insurance that has suitable cover in Ireland. The school insurance covers all students for accident/injury at school but it does not cover medical problems.	

Declaration and Consent Form

Please read the following section carefully. Please get it translated in your own language if you do not understand the questions and declaration of consent form below.
Permission for administration of medicine and treatment of accidents and injuries, whilst on school grounds, by Nurse or Matron or other school staff. This will include emergency treatment and routine treatments such as dressings, regular medications.
I am aware that my son/daughter may have to attend the School Nurse/ Matron whilst at school.
I give permission for him/her to receive (please tick)

A) First Aid Assistance

YES	NO

B) To give him/her over the counter(OTTC) non-prescription medications as necessary

YES	NO

C) To give him/ her medication that is prescribed by their Consultant/GP

YES	NO

D) I consent to the school GP practice, Bandon Medical Clinic, 10 Oliver Plunkett St, Bandon, and Co. Cork, seeing my son/daughter in the event of an accident or illness.

YES	NO

E) I consent to BGS holding data on my child for their medical records in accordance with the data protection and privacy policy of the school.

YES	NO

F) In the event that I the parent/guardian is unable to be contacted in the case of a life threatening emergency I give permission for the school to consent to any treatment that is required to save my child's life in the hospital.

YES	NO

Date:

Signed: Print: