LOMOND SCHOOL
MEDICAL FORM

It is essential that this form be completed and returned to the Headmaster. Please make this as detailed as possible in the interest of your child's health.

NAME OF PUPIL: _____

DATE OF BIRTH: _____ DAY/BOARDER: _____

1. Please circle the infectious diseases he/she has had:	Measles, German Measles, Whooping Cough, Chickenpox, Mumps, Scarlet Fever
2. Does he/she suffer from, or has he/she suffered from any of the following:	
a) Any form of allergy or reaction	…….
b) Attacks of 'wheezy' chest, asthma or bronchitis	…….
c) Fits of epilepsy	…….
d) Hay fever, eczema or any other skin complaint	…….
e) Anxiety, depression or nervous strain	…….
f) Bed-wetting	…….
g) Any other illness, injury or surgical operations	…….

Please give details of any other medical condition: …….....
.....

Has he/she received the following vaccines (give dates):

VACCINE	DATE	VACCINE	DATE
Triple & Polio in infancy and at School entrance (Diptheria, Tetanus and Whooping Cough)		MMR	
		Typhoid	
		Cholera	
Haemophilus (Hib)		Yellow Fever	
Any further Tetanus Booster		Meningitis C	

Name, address and tel. no. of family doctor: . ……..……..……..……

…….. ...….…….. Tel. No. ……..

NHS Card Number: ……...…….…….(if pupil has never registered in NHS please write NONE)

FOR BOARDERS ONLY

In the event of an emergency I wish my son/daughter (or ward) (Name: ……)

a) * to go into the general ward of a hospital) * delete whichever does not apply
b) * to be treated as a private patient)

I agree to …….. receiving inoculation as deemed necessary from the School Doctor for: Diptheria, Influenza, Meningitus C, Tetanus and those vaccines recommended by the WHO for travelling abroad.

I would/would not* like dental treatment to be carried out during term. (* delete as appropriate)

My son/daughter (or ward)'s place of birth is: .....

Signature of Parent/Guardian: …… Date: ……..