St Andrew's College Medical Questionnaire.

It is important that you answer all questions in full.

Where possible any supporting medical documents should be sent with this form.
Failure to disclose any illness will breach the conditions of the application.

Surname:	Forenames:

Date of Birth (dd/mm/yy) :	Religion	Sex : Male ☐ Female ☐

PART 1

PRESCRIPTION MEDICATION

Does your child take any regular medication (which he/she will bring with him/her?)
☐ Yes ☐ No
If yes, please give details

Tick **one** of the below
☐ I would like the House Manager to administer my child's medication and give my consent for them to do so.
☐ I believe my child is able to administer their own medication and give my consent for them to do so.

EMERGENCY MEDICAL TREATMENT

In case of a medical emergency, every effort will be made to contact the child's parent or guardian as quickly as possible. If your child needs an emergency operation, do you give permission for the Director of the school to sign the necessary consent form?
☐ Yes ☐ No
If you have ticked No, please advise what action should be taken?

DIETARY REQUIREMENTS

Halal	☐	Vegetarian	☐
Kosher	☐	Vegan	☐
Gluten Free	☐	Nut free	☐
Lactose Free	☐	No beef	☐
Other (please state)		☐	

Does your son/daughter have any specific learning difficulties i.e. Dyslexia. Dyspraxia, Attention Deficit (Hyperactivity) Disorder or Dyscalculia **Yes** ☐ **No** ☐

Details……

All students should now complete Part 2

PART 2 to be completed by all students/parents if student is under 18 years of age.

Please note that halls of residence are available only to NON smokers.

Please confirm that your son /daughter/you (in the case of over 18s) are a non smoker. Yes ☐ No ☐

Please ensure you have ticked Yes or No.

Signature…… Name ……..

Please answer all of the following questions by ticking the box		**Yes**	**No**
1	Are you regularly attending a hospital, community clinic or seeing a doctor?	☐	☐
	Are you suffering from or have you ever suffered from:	**Yes**	**No**
2	Any conditions relating to your heart or circulation ?	☐	☐
3	Any respiratory problems ? (e.g Asthma)	☐	☐
4	Any psychological problems ? (e.g Eating disorder /depression / self-harm)	☐	☐
5	Any eyesight condition that cannot be corrected by wearing spectacles or contact lenses?	☐	☐
6	Any ongoing hearing problems or ear disorders? (e.g Tinnitus)	☐	☐
7	Any ongoing bone, muscle or joint problems? (e.g Recurrent back pain/Arthritis)	☐	☐
8	Any skin diseases or conditions that require medical treatment?	☐	☐
9	Any gastro-intestinal or abdominal problems? (e.g Hernia/Gall Stones)	☐	☐
10	Any blood or metabolic disorders? (e.g Anaemia/Diabetes)	☐	☐
11	Any neurological conditions? (e.g severe headaches/vertigo/epilepsy)	☐	☐
12	Any long term or debilitating illness? (e.g Multiple Sclerosis)	☐	☐

IF YOU HAVE ANSWERED YES TO ANY OF THE QUESTIONS ON PART2, YOU MUST NOW COMPLETE THE REMAINING SECTIONS OF **PART 3** .

If you have answered NO to all the questions in **PART 2** please sign and date at the end of the questionnaire.

PART 3

Heart and Circulation		**Yes**	**No**	**Details**
(a)	Heart attack	☐	☐	
(b)	Angina	☐	☐	
(c)	Other heart disease, or abnormal heart rhythm	☐	☐	
(d)	Chest pain	☐	☐	
(e)	Stroke / mini stroke	☐	☐	
(f)	High blood pressure	☐	☐	
(g)	Palpitations	☐	☐	
Respiratory		**Yes**	**No**	**Details**
(a)	Shortness of breath or coughing	☐	☐	
(b)	Bronchitis	☐	☐	
(c)	Asthma	☐	☐	
(d)	Any other lung disorder	☐	☐	
(e)	*Do you smoke?*	☐	☐	
Psychological health		**Yes**	**No**	**Details**
(a)	Nervous breakdown, panic attacks, phobias, neurosis	☐	☐	
(b)	Psychosis, schizophrenia, obsessive/compulsive disorder	☐	☐	
(c)	Anxiety, depression	☐	☐	
(d)	Severe stress	☐	☐	
(e)	Eating disorder	☐	☐	
(f)	Have you ever tried to harm yourself?	☐	☐	
Eyesight		**Yes**	**No**	**Details**
(a)	Eye disease, infection, inflammation, bleeding	☐	☐	
(b)	Glaucoma, disease of the retina	☐	☐	
(c)	Have you undergone any eye surgery	☐	☐	
Hearing		**Yes**	**No**	**Details**
(a)	Are you aware of any hearing problems?	☐	☐	
(b)	Non infective ear disorder (e.g. tinnitus, vertigo)	☐	☐	
(c)	Infective ear disease (e.g. discharge, glue ear)	☐	☐	
(d)	Hearing loss	☐	☐	

Gastro-Intestinal/Abdominal		**Yes**	**No**	**Details**
(a)	Hernia	☐	☐	
(b)	Any bowel problems (e.g Colitis, chronic diarrhoea, Irritable Bowel Syndrome, Crohns,	☐	☐	
(c)	Gall stones, pancreatitis,	☐	☐	
(d)	Jaundice or Hepatitis A	☐	☐	
(e)	Kidney problems, renal stones	☐	☐	
(f)	Chronic indigestion, stomach, peptic or duodenal ulcers	☐	☐	
(g)	Infections (e.g. typhoid, paratyphoid fever, salmonella, cholera)	☐	☐	
(h)	Recurring abdominal pains, gynaecological problems	☐	☐	
(i)	Severe problems with appetite or digestion	☐	☐	
(j)	Frequent need for the toilet or incontinence	☐	☐	
Blood/Metabolic disorder		**Yes**	**No**	**Details**
(a)	Any blood disorder, disorder of lymph glands, anaemia, leukaemia	☐	☐	
(b)	Any congenital disorder manifested through the blood? *(If yes, please give details)*	☐	☐	
(c)	Any disease carried through the blood (e.g. Hepatitis B.)	☐	☐	
(d)	Thyroid, pituitary or hormone disorder	☐	☐	
(e)	Diabetes Mellitus *If yes, do you require insulin injections on a strict timetable*	☐ ☐	☐ ☐	
Neurological		**Yes**	**No**	**Details**
(a)	Headaches, cluster headaches, migraines *If yes, please indicate severity (mild, moderate or severe, and how often you get them.)*	☐	☐	
(b)	Severe head injury/Concussion	☐	☐	
(c)	Fits, blackouts, fainting, loss of balance, double vision, vertigo	☐	☐	
(d)	Epilepsy	☐	☐	

General Medical		**Yes**	**No**	**Details**
(a)	Cancer	☐	☐	
(b)	Have you ever had a tropical disease? (e.g. malaria)	☐	☐	
(c)	Other debilitating illnesses (e.g multiple sclerosis, Parkinsons disease) *(If yes, please give details)*	☐	☐	
(d)	Do you suffer from any medical condition affecting your sleep? *(if yes, please give details)*	☐	☐	
(e)	Have you ever had any medical condition not mentioned above that has involved your G.P., a hospital or specialist?(If yes, please give details)	☐	☐	
(f)	Allergies *(If yes, please give details)*	☐	☐	
(g)	Operations *(If yes, please give details)*	☐	☐	
(h)	Are you currently taking any prescribed tablets or medication or receiving injections (If yes, please specify type and timetable)	☐	☐	

I certify that I have answered all questions to the best of my ability and knowledge.

This should be signed by the parent where the student is under 18.

Signed : _____ Date: / /

Print Name: _____

St Andrew's College will organise if requested access to specialist services for mental health issues however, the student and family will be liable for any costs involved.