

MEDICAL QUESTIONNAIRE

Student Details

First Name			
Date of Birth			
Nationality			
Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
Emergency Number <i>(Please indicate all codes, including country code)</i>			
<p>Only non-smoking students are allowed to live in halls of residence. If a student starts smoking or is found smoking after arrival they will be removed from halls of residence and will not receive a refund of accommodation fees. Please confirm that your son /daughter (in the case of over 18s) are a non- smoker.</p>			
DO YOU SMOKE?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>

Prescription Medication

Does your child take any regular medication (which he/she will bring with him/her?)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please give details:		
I would like St. Andrew's staff or the homestay host to administer my child's medication and give my consent for them to do so.	<input type="checkbox"/>	
I believe my child is able to administer their own medication and give my consent for them to do so.	<input type="checkbox"/>	

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 <input type="checkbox"/>	No <input type="checkbox"/>
If you have ticked No, please advise what action should be taken?		

Learning Difficulties

Does your child have any specific learning difficulty? eg dyslexia, dyspraxia, attention deficit disorder or dyscalculia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please give details:		

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Medical History

Please answer all of the following questions by ticking the box	Yes	No
Are you regularly attending a hospital, community clinic or seeing a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Are you suffering from or have you ever suffered from:		
Any conditions relating to your heart or circulation?	<input type="checkbox"/>	<input type="checkbox"/>
Any respiratory problems (eg asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
Any psychological problems (eg: eating disorder / depression / self-harm)?	<input type="checkbox"/>	<input type="checkbox"/>
Any eyesight problem that cannot be corrected by wearing spectacles or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Any ongoing hearing problems or ear disorders (eg tinnitus)?	<input type="checkbox"/>	<input type="checkbox"/>
Any ongoing bone, muscle or joint problems (eg recurrent back pain / arthritis)?	<input type="checkbox"/>	<input type="checkbox"/>
Any skin diseases or conditions that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Any gastro-intestinal or abdominal problems (eg hernia / gall stones)?	<input type="checkbox"/>	<input type="checkbox"/>
Any blood or metabolic disorders (eg diabetes / anaemia)?	<input type="checkbox"/>	<input type="checkbox"/>
Any neurological conditions (eg severe headaches / epilepsy / vertigo)?	<input type="checkbox"/>	<input type="checkbox"/>
Any long term or debilitating illness (eg multiple sclerosis)?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered YES to any of the above questions, you must now complete the remaining sections.

If you have answered NO to all the above questions, please sign and date at the end of the questionnaire.

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Heart and Circulation		Yes	No	Details
A	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
B	Angina	<input type="checkbox"/>	<input type="checkbox"/>	
C	Other heart disease or abnormal heart rhythm	<input type="checkbox"/>	<input type="checkbox"/>	
D	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
E	Stroke / mini stroke	<input type="checkbox"/>	<input type="checkbox"/>	
F	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
G	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory		Yes	No	Details
A	Shortness of breath or coughing	<input type="checkbox"/>	<input type="checkbox"/>	
B	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	
C	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
D	Any other lung disorder	<input type="checkbox"/>	<input type="checkbox"/>	
E	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	
Psychological Health		Yes	No	Details
A	Nervous breakdown, panic attacks, phobias, neurosis	<input type="checkbox"/>	<input type="checkbox"/>	
B	Psychosis, schizophrenia, obsessive/compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>	
C	Anxiety or depression	<input type="checkbox"/>	<input type="checkbox"/>	
D	Severe stress	<input type="checkbox"/>	<input type="checkbox"/>	
E	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	
F	Have you ever tried to harm yourself?	<input type="checkbox"/>	<input type="checkbox"/>	
Eyesight		Yes	No	Details
A	Eye disease, infection, inflammation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
B	Glaucoma, disease of the retina	<input type="checkbox"/>	<input type="checkbox"/>	
C	Have you undergone any eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	

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Hearing		Yes	No	Details
A	Are you aware of any hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	
B	Non infective ear disorder tinnitus, vertigo?	<input type="checkbox"/>	<input type="checkbox"/>	
C	Infective ear disease (eg discharge, glue ear)	<input type="checkbox"/>	<input type="checkbox"/>	
D	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	
Gastro-intestinal / abdominal		Yes	No	Details
A	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
B	Bowel problems (eg colitis, chronic diarrhoea, irritable bowel syndrome, Crohn's)	<input type="checkbox"/>	<input type="checkbox"/>	
C	Gall stones, pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	
D	Jaundice or hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	
E	Kidney problems, renal stones	<input type="checkbox"/>	<input type="checkbox"/>	
F	Chronic indigestion, stomach, peptic or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
G	Infections (eg typhoid, paratyphoid fever, salmonella, cholera)	<input type="checkbox"/>	<input type="checkbox"/>	
H	Recurring abdominal pains, gynaecological problems	<input type="checkbox"/>	<input type="checkbox"/>	
I	Severe problems with appetite or digestion	<input type="checkbox"/>	<input type="checkbox"/>	
J	Frequent need for the toilet or incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Blood / metabolic disorder		Yes	No	Details
A	Any blood disorder, disorder of lymph glands, anaemia, leukaemia	<input type="checkbox"/>	<input type="checkbox"/>	
B	Any congenital disorder manifested through the blood?	<input type="checkbox"/>	<input type="checkbox"/>	
C	Any disease carried through the blood (eg hepatitis B)	<input type="checkbox"/>	<input type="checkbox"/>	
D	Thyroid, pituitary or hormone disorder	<input type="checkbox"/>	<input type="checkbox"/>	
E	Diabetes melitus If yes, do you require insulin injections on a strict timetable	<input type="checkbox"/>	<input type="checkbox"/>	

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Neurological		Yes	No	Details
A	Headaches, cluster headaches, migraines If yes, please indicate severity (mild, moderate or severe, and how often you get them)	<input type="checkbox"/>	<input type="checkbox"/>	
B	Severe head injury / concussion	<input type="checkbox"/>	<input type="checkbox"/>	
C	Fits, blackouts, fainting, loss of balance, double vision, vertigo	<input type="checkbox"/>	<input type="checkbox"/>	
D	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
General Medical		Yes	No	Details
A	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
B	Have you ever had a tropical disease (eg malaria)?	<input type="checkbox"/>	<input type="checkbox"/>	
C	Other debilitating illnesses (eg multiple sclerosis, Parkinson's disease) If yes, please give details	<input type="checkbox"/>	<input type="checkbox"/>	
D	Do you suffer from any medical condition affecting your sleep? If yes, please give details	<input type="checkbox"/>	<input type="checkbox"/>	
E	Have you ever had any medical condition not mentioned above that has involved your GP, a hospital or specialist If yes, please give details	<input type="checkbox"/>	<input type="checkbox"/>	
F	Allergies If yes, please give details	<input type="checkbox"/>	<input type="checkbox"/>	
G	Operations If yes, please give details	<input type="checkbox"/>	<input type="checkbox"/>	
H	Are you currently taking any prescribed tablets or medication or receiving injections If yes, please specify type and timetable	<input type="checkbox"/>	<input type="checkbox"/>	

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

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

Print Name:

Signed:

Date: