Health Questionnaire

MANCHESTER MUSLIM PREPARATORY SCHOOL
FAITH • LEARNING • LIFE

Please complete and return the questionnaire in a sealed envelope marked for the attention of school office. This information will be shared with designated school staff and treated in strict confidence.

Year Group: ____ Date of Birth ____

Pupil's First Name: ____ Pupil's Surname: ____

Parent/Carer's Names: ____

Address: ____

____ Postcode: ____

Telephone: ____ Mobile: ____

Email: ____

Emergency contact's name and number

Name & Address of GP: ____

____ Postcode: ____

NHS Number (if known): ____

Medical Conditions

Please indicate below if your son/daughter has any of the following medical conditions or difficulties.

Condition	Yes	No
Asthma *(We recommend a spare inhaler is left in the school* office)	○ Yes	○ No
Diabetes *(please indicate type)*	○ Yes	○ No
Skin condition e.g. eczema	○ Yes	○ No
Heart Conditions *e.g. has a pacemaker*	○ Yes	○ No
Dietary conditions *e.g. Coeliac, gluten free diet*	○ Yes	○ No
Hearing e.g. wears a hearing aid, needs to sit at the front of the classroom	○ Yes	○ No
Epilepsy	○ Yes	○ No
Any other medical conditions not listed above	○ Yes	○ No
Mobility e.g. spinal problems	○ Yes	○ No
Bladder or bowel problems	○ Yes	○ No
Blood Conditions *e.g. anaemia*	○ Yes	○ No
Severe migraines/ headaches	○ Yes	○ No
Serious allergies Does this require adrenaline in school *(Epipen)*?	○ Yes	○ No
Vision • Wears glasses in general • Glasses for reading • Wears contact lenses	○ Yes	○ No
Anxiety/Panic attack	○ Yes	○ No

If you have answered YES to any of the options above, please give details of any medication required for each condition, which health professionals help manage your child's condition e.g. hospital team, GP or other service. Please provide details of how their condition may affect their participation in school activities e.g. sports

Will your son/daughter need medication during school hours? ◯ Yes ◯ No

If you said Yes please provide details below:

N.B Any medication should be sent to the office with clear instructions for both use and storage

Will your son/daughter be attending regular medical/dental appointments? ◯ Yes ◯ No

If you said Yes please provide details below:

Any updates with regard to medical conditions, medication or contact details must be reported to office immediately in writing.

All data collected will be used in line with GDPR (General Data Protection Regulation).

Signed: Date: / /