**Health Information for Great Oaks College**

Please ensure that you inform Great Oaks College and the relevant health services regarding changes in your student’s health, e.g changes in diagnosis, medication and any changes in their care that may impact on how they are looked after during the College day. Please provide copies of all relevant care plans.

Boxes in yellow are for administrative purposes and will be filled in by College staff.

**Personal and Family Information**

**Personal Details and Next of Kin**

|  |  |  |  |
| --- | --- | --- | --- |
| Young person’s name |  | Date of Birth |  |
| NHS Number |  | Home telephone Number |  |
| Address |  | Parent 1’s name |  |
|  | Parent 1’s Mobile Number |  |
|  | Parent 2’s Name |  |
| Religion |  | Parent 2’s Mobile Number |  |
| Home Language |  | Ethnicity |  |
| Do you require an interpreter? | [ ]  Yes Please specify the language:[ ]  No |

 **GP information**

|  |  |
| --- | --- |
| GP Name |  |
| GP Address |  |
|  |
| GP Phone number |  |

**Emergency Contact Information**

|  |
| --- |
| Emergency Contact 1 |
| Name |  |
| Relationship to Student |  |
|  |
| Telephone Number |  |

|  |
| --- |
| Emergency Contact 2 |
| Name |  |
| Relationship to Student |  |
|  |
| Telephone Number |  |

**General Information**

|  |  |
| --- | --- |
| What is the student’s main method of communication? |  |
| What methods of communication does the student use? | [ ]  Verbal [ ]  Makaton [ ]  PECs | [ ]  Choosing Pictures [ ]  Communication Book/Board [ ]  Eyegaze[ ]  Other |
| Does the student use a wheelchair?  | Always/Part Time/Occasionally/Never |
| Does the student have a medical passport? | [ ]  Yes [ ]  No | Is the passport attached? | [ ]  Yes [ ]  NoRef: |

 **Medical Overview**

*Please tick all that apply, so we can ensure student needs are fully met.*

|  |  |  |  |
| --- | --- | --- | --- |
| Severe Learning Difficulty (SLD)  | [ ]  | Allergy | [ ]  |
| Profound and Multiple Learning Difficulties | [ ]  | Tube Feed (Gastrostomy/Jujunostomy/NG Tube) | [ ]  |
| Autism | [ ]  | Eating Difficulties (Thickened Food/Supplements) | [ ]  |
| Epilepsy/History of Epilepsy | [ ]  | Asthma | [ ]  |
| Emergency Medication | [ ]  | Eczema | [ ]  |
| Medication during College Day | [ ]  | Visual Impairment | [ ]  |
| Oxygen Therapy/CPAP/BIPAP | [ ]  | Hearing Impairment | [ ]  |
| Tracheostomy/NPA | [ ]  | Urinary Catheter | [ ]  |
| Suctioning | [ ]  | Colostomy/Illistomy | [ ]  |
| Shunt | [ ]  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  |

**Medical Details**

**Diagnosis**

|  |  |
| --- | --- |
| What medical diagnoses and medical problems does the student have?  | You will be asked to expand on some categories later. |

**Significant Recent Medical History**

|  |  |
| --- | --- |
| Please list any surgery or change in health needs over the last 12 months |  |

**Physical/Sensory Disability**

|  |  |
| --- | --- |
| Does the student have a physical disability?  |  [ ]  Yes [ ]  No - Move on to next section |
| If Yes, please give details |  |
| If Yes, does the student have mobility aids/physio equipment in College?  |  |
| Does the student have a Visual/Hearing Impairment?  |  [ ]  Yes [ ]  No |
| If Yes, please give details |  |
| Consultant’s Name:  |   |
| Consultant’s Contact Number/Email |  |

**Oxygen/Breathing**

|  |  |
| --- | --- |
| Does the student have any problems with breathing?  |  [ ]  Yes [ ]  No - Move on to next section |
| If Yes, please give details |  |
| If yes, does the student have a care plan?  |  | Care Plan attached | [ ]  Yes [ ]  NoRef: |
| Consultant’s Name:  |  |
| Consultant’s Contact Number/Email |  |

**Diet**

|  |  |
| --- | --- |
| Does the student have any dietary needs?  |  [ ]  Yes – Tube Feed [ ]  Yes – Thickened Drinks/Food [ ]  Yes – Nil By Mouth [ ]  Yes – Allergy [ ]  Yes – Does not eat certain foods [ ]  Yes – Nutritional Supplements [ ]  No - Move on to next section |
| If Yes, please give details |  |
| If yes, does the student have a dietary plan?  |  | Dietary Plan attached | [ ]  Yes [ ]  NoRef: |
| Dietician’s Name:  |  |
| Dietician’s Contact Number/Email |  |

**Allergies**

|  |  |
| --- | --- |
| Does the student have any known allergies?  |  [ ]  Yes [ ]  No - Move on to next section |
| If Yes, please give details |  |
| If Yes, does the student have allergy medication?  |  | Medication Consent form updated |  |
| If yes, does the student have an allergy plan?  |  | Allergy Plan attached | [ ]  Yes [ ]  NoRef: |

**Asthma**

|  |  |
| --- | --- |
| Does the student have asthma?  |  [ ]  Yes [ ]  No - Move on to next section |
| If Yes, please give details |  |
| If yes, does the student have an asthma plan?  |  | Asthma Plan attached | [ ]  Yes [ ]  NoRef: |
| If Yes, does the student have medication? |  | Medication Consent form updated |  |
| Consultant’s Name:  |  |
| Consultant’s Contact Number/Email |  |

**Seizures**

|  |  |
| --- | --- |
| Does the student have seizures?  |  [ ]  Yes – Epilepsy [ ]  Yes – Non-Epileptic Seizures [ ]  Yes – Drop Episodes/Other [ ]  No - Move on to next section |
| If Yes, please give details |  |
| If yes, does the student have a seizure care plan?  |  | Seizure Plan attached | [ ]  Yes [ ]  NoRef: |
| If Yes, does the student have rescue medication? |  | Medication Consent form updated |  |
| Consultant’s Name:  |  |
| Consultant’s Contact Number/Email |  |

**Other**

|  |  |
| --- | --- |
| Do you have any other medical information you would like us to be aware of?  |  [ ]  Yes [ ]  No - Move on to next section |
| Please give details |  |

**Medications**

**Medications (Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

Please indicate **ALL** regular and as required medications that your young person takes, including medications that are given at home.

This information will be given to hospital doctors if we ever have to call an ambulance. Please make sure you notify us as soon as possible of any changes.

**Emergency Medications**

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Details of Administration |
|  |  |  |
|  |  |  |
|  |  |  |

**Routine Medications**Please continue on a separate sheet if needed.

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Time Taken | Taken in College?  |
|  |  |  | [ ]  Yes [ ]  No |
|  |  |  | [ ]  Yes [ ]  No |
|  |  |  | [ ]  Yes [ ]  No |
|  |  |  | [ ]  Yes [ ]  No |
|  |  |  | [ ]  Yes [ ]  No |
|  |  |  | [ ]  Yes [ ]  No |

**Any significant side effects that may impact upon College activities:**

|  |
| --- |
|  |

**Change in medications (Date amended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Signed by :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Time Taken | Taken in College?  |
|  |  |  | [ ]  Yes [ ]  No |
|  |  |  | [ ]  Yes [ ]  No |
|  |  |  | [ ]  Yes [ ]  No |

**Care Team**

**Health Professionals**Please tick and provide any names and contact details of any other professionals involved in the student’s care.

|  |  |
| --- | --- |
| Health Visitor |  |
| Physiotherapist |  |
| Speech and Language Therapist |  |
| Occupational Therapist |  |
| Hearing Impairment Team |  |
| Visual Impairment Team |  |
| Other Professionals |  |

**Social care involvement**

|  |  |
| --- | --- |
| Social Worker |  |
| Social Work Team |  |
| Does the student have a Young person in Need Plan?  | [ ]  Yes [ ]  No | Does the student have a Young person Protection Plan?  | [ ]  Yes [ ]  No |

Thank You for taking your time to complete this form and help us provide the best care for your College student.

I confirm that the information given is correct at the time of signing, and I understand that I need to notify Great Oaks College as soon as possible of any change in the student’s care needs or medications.

 **Signature of parent / carer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_

 **Signature of processing professional**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_