NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

My Personalised Special School Nursing Booklet

Name of Child/Young Person: ……

WELCOME

I would like to take this opportunity of welcoming you and your child to the Staffordshire Special School Health service. This booklet is designed to follow your child throughout their school life to ensure health needs are fully met and to support transition into adult life.

The booklet will need to be completed at various times in your child's journey throughout their education. The main parts are:

- Initial Assessment
- Year 6 Check List
- Year 9 Transition Review

Could you please complete the initial health questionnaire, medicine administration forms and consent at your earliest convenience.

Please return the completed health questionnaire booklet along with consent forms and administration of medication form to your child's Named School Nurse.

The information contained within this booklet will be stored in your child's file. You are welcome to contact your School Nurse at any time during your child's school life on any health issues that may affect them in school. However in case of an emergency and your child's Named Nurse is not available please contact the school and they will try to locate a member of the Special School Nursing Team.

Information to support meeting your child's health needs

In order to ensure that our nursing team are able to maintain your child's health and wellbeing during their school day it is essential that we are kept updated frequently / as required.

It is your responsibility as parent / guardian to communicate with the nursing team if your child has:

- Prescribed medication to be administered at school. This must be labelled correctly. Any changes to medication must have a doctor's letter confirming change. Any medication that can be administered at home should be.

- Any illness / admission to hospital your child experiences must be reported as soon as possible which includes illness / admission to hospital that occur during school holidays. Either let the nursing staff know at the beginning of that term on return to school or email specialschools.staffs@nhs.net.

- Impending health appointments or appointments that have occurred during an absence from school.

- If your child receives enteral feeding or any other clinical intervention in school please ensure all necessary equipment is sent in. This should include syringes, extension tubes, gravity feed packs.

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INITIAL HEALTH QUESTIONNAIRE

INFORMATION GIVEN ON THIS BOOKLET WILL BE TREATED AS **STRICTLY CONFIDENTIAL**

Childs Name:	NHS number:	Date of Birth:	Ethnicity:
Address: Postcode:			
Parent/ Guardian: (person with parental responsibility)			
Contact Telephone Numbers Home: Mobile:		Does your child have a Social Worker? Name of Social Worker:	
Family Summary/Structure:			
Previous School/ Nursery:		Current School:	
G.P. name: G.P.s Address: Postcode:			
Name of previous Health Visitor/ School Nurse:			

For Office Use Only	Details
Date questionnaire received	
Consent Obtained	
Immunisation form completed	
Professional's involved form completed	
Date child seen	
Height	Cms centile
Weight	Kgs centile
Further action required?	List action:
Date action completed:	

Question 1. Does your child have any long-term health problems?

YES NO If YES please circle

Epilepsy Diabetes Asthma Eczema

Autism ADHD Shunt Serious Allergies

Other: please specify

……

Question 2. What is your child's medical diagnosis?

……

Question 3. Does your child regularly attend the hospital?

YES NO If YES

Please state reason ……..

……

……

Question 4. Does your child need regular medication DURING school hours?

YES NO If YES complete medication form

This form will need to be completed annually/as required.

Question 4a. Does your child need regular medication OUTSIDE school hours?

YES NO If YES complete medication form

This will need to be completed annually/as required.

Question 5. Are your child's immunisations up to date (including pre-school booster)?

YES NO NOT SURE

If NO or NOT SURE please contact your doctor's surgery to make an appointment as soon as possible.

Question 6. a. Do you have any concerns about your child's hearing?

YES NO If YES

Please give details ……

……

b. If Yes would you like your child to be referred to audiology?

YES NO

c. Does your child wear a hearing aid?

YES NO If YES

Please give details ……

……

Question 7. Does your child have any speech problems?

YES NO If YES

Please give details ……

……

Question 8. Does your child see a Speech and Language Therapist?

YES NO If yes please ensure your child's Speech and Language Therapist name and contact details are on Professionals contact form.

Please give details why your child sees a speech and language therapist

……

……

Question 9. Does your child use communication aids?

YES NO If YES

Please circle: PECS MAKATON SIGN LANGUAGE

Question 10. a. Does your child wear glasses?

YES NO

If you have concerns regarding your child's vision, please make an appointment with your local opticians; if you require support please contact your school nurse.

Question 11. a. Does your child suffer from constipation or other toileting problems?

YES NO If YES

Please give details ……

……

b. Or day or night time wetting?

YES NO If YES

Please give details ……

……

c. Does your child use continence products? Eg. Nappies.

YES NO

If Yes please note an annual assessment will be completed

Please give details of products used

……

……

Question 12. Does your child have any problems with eating / diet / weight?

YES NO If YES

Please give details ……

……

Question 13. Does your child see the dietician?

YES NO If yes please ensure your child's dietician name and contact details are on professionals contact form.

Question 14. Do you have any concerns about your child's behaviour?

YES NO If YES

Please give details ……

……

Please ensure your child's Learning Disability Nurse/ therapist name and contact details are on professionals contact page

Question 15. a. Does your child have any problems with mobility?

YES NO If YES

Please give details ……

……

b. Does this affect your child's physical education?

YES NO If YES

Please give details ……

……

Question 16. Does your child see the physiotherapist / occupational therapist?

YES NO If YES

Please give details ……

……

Please ensure your child's physiotherapist / occupational therapist name and contact details are on Professionals contact page.

Question 17. Does your child have sleep problems?

YES NO If YES

Please give details ……

……

Question 18. Does your child regularly see a dentist?

YES NO If YES

Please give details ……

……

Question 19. What is your child's religion/beliefs? Please give details.

……..

Question 20. Does anyone in the household smoke?

YES NO

b. Would you like advice or support in giving up smoking?

YES NO

Please ensure all parts of the assessment are completed, Consent Form, Annual Medication Form, Professional forms **Should you wish to share any other details regarding your child's health please use continuation sheet**.

Depending on completion of this form further questionnaires may be sent home to be completed to enable nurses to complete care plans.

Thank you very much for taking the time to complete this questionnaire.

Signed ……

Print Name: ..... Date: .....

Please state your relationship to child……

Do you have parental responsibility? Please circle Yes No Not Sure

Please indicate if you would like an appointment with the school nurse to discuss any of the points above

Yes No

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Fountains Primary School,
Bitham Lane, Stretton,
Burton upon Trent, DE13 0HB

Dear Parent / Carer

ln order to ensure that your child's health and wellbeing are maintained during their time at Fountains Primary School, it may be necessary for us to share information and / or request information with other professionals or teachers regarding your child's needs.

lt may also be necessary to check and assess your child's growth on an annual / as required basis by the school nurse /outside agency.

We require consent to store and share information according to GDPR.

Please provide consent to the following if applicable

Reason	Signature	Date
I give permission for appropriate information to be obtained regarding my child's health from appropriate health professionals / teaching staff. This is usually in the form of requesting copies of recent clinic appointments from named Consultant's, confirmation of medication regimes from your G.P. etc.		
I give permission for any relevant information regarding my child's health being shared with other professionals / teaching staff.		
If the school nurse is unable to contact the parent/carer I give permission for my child to be seen by the school nurse if a concern is raised at school e.g. child is unwell / temperature etc.		
I give permission for my child's weight and height to be measured.		

Please complete this form if you give consent for your child to be seen by the School Nursing Team if required while they remain a pupil at Fountains Primary School.

You have the right to change your permission to consent at any time, please contact the school nurse.

Childs Name: ..... DOB: .....

NHS No: .....

Signed: ..... (Person with parental responsibility to sign)

Print Name: ..... Date: .....

Parental responsibility - Parental Responsibility has been defined as all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his or her property. Parental Responsibility gives parent legal rights in respect of the child.

PROFESSIONALS / AGENCIES INVOLVED IN YOUR CHILD'S CARE

Physiotherapist Name : Address : Tel No :	**Occupational Therapist** Name : Address : Tel No :
Consultant Speciality Name : Address Tel No :	**Consultant** Speciality Name : Address : Tel No :
Consultant Speciality Name Address : Tel No :	**Speech and Language Therapist** Name : Address : Tel No :
Dietitian Name : Address : Tel No :	**Shared Care / Direct Payments carer** Name : Address : Tel No :
Opticians Name : Address : Tel No :	**Respite / Hospice** Name : Address : Tel No :

PLEASE COMPLETE WITH AS MUCH INFORMATION AS POSSIBLE

PROFESSIONALS / AGENCIES INVOLVED IN YOUR CHILD'S CARE

Community Children's Nurse Name : Address : Tel No :	**Local Support Team** Name : Address : Tel No :
Health Visitor Name : Address : Tel No :	**Learning Disability Team** Name : Address : Tel No :
Other	**Other**

PLEASE COMPLETE WITH AS MUCH INFORMATION AS POSSIBLE

If you require this document to be translated into a different language or in a different format (such as easy read or large print, audio) then please contact specialschools.staffs@nhs.net

Routine Childhood Immunisations

Age due	Diseases protected against	Vaccine given	Date Vaccine Given
8 weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib), and hepatitis B	DTaP/IPV/Hib/HepB	
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	
	Meningococcal group B (MenB)	MenB	
	Rotavirus gastroenteritis	Rotavirus	
12 weeks old	Diphtheria, tetanus, pertussis, polio, Hib, and hepatitis B	DTaP/IPV/Hib/HepB	
	Rotavirus	Rotavirus	
16 weeks old	Diphtheria, tetanus, pertussis, polio, and Hib, and hepatitis B	DTaP/IPV/Hib/HepB	
	Pneumococcal (13 serotypes)	PCV	
	MenB	MenB	
1 year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	
	Pneumococcal	PCV	
	Measles, mumps, and rubella (German measles)	MMR	
	MenB	MenB Booster	
Eligible paediatric age groups	Influenza (each year from September)	Live attenuated influenza vaccine LAIV	
3 years 4 months old or soon after	Diphtheria, tetanus, pertussis, and polio	DTaP/IPV	
	Measles, mumps, and rubella	MMR (check first dose given)	
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and l l)	HPV (two doses 6-24 months apart)	
14 years old (school year 9)	Tetanus, diphtheria, and polio	Td/IPV (check MMR status)	
	Meningococcal groups A, C, W, and Y disease	MenACWY	

Annual Medication Record Consent Form

Pupil's Name: …….. D.O.B: …….. NHS No: ……..

Does your child have any allergies?

Important — Could you please complete giving full details of your child's medications including names, dosages and times to be administered during school and also those that are administered at home.

Name of Medication	Dosage	Time	Special Instructions

If during this term your child's medication or dose is changed by a prescribing health professional, please inform us in writing immediately.

Important

I do/do not (please delete as appropriate) give permission for a trained member of staff who agrees to act on your behalf to administer medicine prescribed by my doctor

- All medicines should be in their original container, clearly labelled with your child's name.
- If you give any extra medication e.g. Paracetamol before leaving for school could you please inform the school.
- The above named pupil only whilst attending school.
- Any medication no longer required will be returned home for safe disposal.
- In the event that prescribed medication is not available, parents/carers will be contacted.
- Your child may be sent home if there are concerns about the impact on their health or wellbeing.
- Medication can only be administered by suitably trained education or healthcare staff. In the event that suitably trained staff are not available to administer medication, parents/carers will be informed to make decision regarding the medicine.

I do/do not (please delete as appropriate) give permission for a trained member of staff to administer First Aid may my child require. This includes using non-prescribed items (see below)

- Plasters and non-adhesive dressings.
- Vaseline/Sudocrem
- Micropause tape
- Sterile dressing

(Please delete any of the above non-prescribed items I do not wish my child to receive).

Signed……(parent/carer) Print name (parent/carer)……

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Date……

Please sign and return this form as soon as possible

Received in school by…….. Date…..