**Medical/Health Questionnaire**

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| As part of the Education, Health and Care Assessment process, the Local Authority is required to seek medical/health advice if a child/young person’s learning is affected by a medical condition. The purpose of this questionnaire is to ensure that any medical or health concerns that do or may have an impact on the child/young person’s education are gathered appropriately.**This questionnaire should be completed by/with the parent/carer of the child/young person undergoing statutory assessment for an Education, Health and Care plan and returned to** **senteam@dudley.gov.uk** **.** |
| **Child/Young Person’s Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **NHS Number:** |  |
| **Name of General Practitioner:**  |  |
| **Address of Medical Practice:**  |  |
| **Current Educational Setting (if applicable):** |  |
| **Medical History:** |
| Medical Diagnosis including suspected diagnosis or tests underway.  |
| Do you have any other concerns about your child/young person’s health? |
| Yes | No |
| If Yes, what? |
| Have you discussed the concerns you have regarding your child/young person’s health with your GP? |
| Yes | No |
| **Please be aware that the SEND Team cannot make referrals to Health Teams on your child/young person’s behalf.** **Please ensure that you discuss any concerns with your GP.** |
| Are they under the care of a hospital Consultant(s)? |
| Yes | No |
| If so, please give the consultant’s name and the name of the hospital/clinic  |
| Are they known to any other Health Care Professionals? | Yes | No | Name and contact details | Date last seen |
| Physiotherapist |  |  |  |  |
| Occupational Therapist |  |  |  |  |
| Speech and Language Therapist |  |  |  |  |
| Child and Adolescent Mental Health Team (CAMHS) |  |  |  |  |
| Adult Mental Health Team |  |  |  |  |
| Childrens Community Nurse Team |  |  |  |  |
| Health Visitor |  |  |  |  |
| School Health Advisor |  |  |  |  |
| Learning Disability Nurse |  |  |  |  |
| Clinical Nurse Specialist |  |  |  |  |
| Other |  |  |  |  |
| Does your child have a Health Care Plan/Package? | Yes  | No |
| If yes, please provide reasons for Plan/Package.  |
| Is your child/young person on any medical treatment or medication? |
| Yes | No |
| Please give name, doses and times given:  |
| Does your child’s health or behaviour pose any risk to themselves or to others whilst in school? |
| Yes | No |
| If yes, what?  |
| Is there any family medical history you would like to share?   |
| Yes  | No |
| Is there anything else you think we should know?  |
| Yes | No |
| If yes, what?  |
| **Declaration** * All information within this questionnaire is true and accurate at the time of writing
* I am aware that the information within this questionnaire may be shared with the

 appropriate and necessary professionals involved in the Education, Health and Care  Assessment process. |
| Name: Parent/Carer:Signed:Date: | Name: Job title: Signed Date: |