**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**](mailto: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: | | | | |