St. Patrick's Special School

Drumgoold, Enniscorthy, Co. Wexford

Email:
principal@stpatricksschool.ie

Telephone: 053-9239150

Principal: Lee Rogers
Deputy: Ann Marie Furlong

Medical Information

Name: _____

D.O.B _____

Address:

Next of Kin: _____

Relationship: _____

Contact Number: _____ _____

Address:

Next Contact: _____

Relationship: _____

Contact Number: _____ _____

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Address:

Medical History: (from birth, including operations etc.)

Diagnosis:

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GP Details:

Name: _____

Address: _____

_____

Contact Number: _____

Activities of Daily Living:

1. **Breathing & Circulation**

• **Asthma**	**Yes ☐**	**No ☐**
• **Use of Inhalers or Nebulisers**	**Yes ☐**	**No ☐**
• **Use of Oxygen**	**Yes ☐**	**No ☐**
• **Suctioning**	**Yes ☐**	**No ☐**

2. **Communication**

• **Verbal/Non-Verbal**	**Yes ☐**	**No ☐**
• **Preferred use of Communication**	**Yes ☐**	**No ☐**
• **Hearing Impairment**	**Yes ☐**	**No ☐**
• **Visual Impairment**	**Yes ☐**	**No ☐**

3. Eating & Drinking

• **PEG fed**	**Yes ☐**	**No ☐**
• **NG tube**	**Yes ☐**	**No ☐**
• **Liquidised**	**Yes ☐**	**No ☐**
• **Thickened drinks**	**Yes ☐**	**No ☐**
• **Specialised diet**	**Yes ☐**	**No ☐**
• **Allergies**	**Yes ☐**	**No ☐**

4. Medication

• **Receive regular Medication**	**Yes ☐**	**No ☐**
• **Prescription Chart**	**Yes ☐**	**No ☐**
• **Use of PRN medication discussed**	**Yes ☐**	**No ☐**
• **Epileptic**	**Yes ☐**	**No ☐**
• **Epilepsy Chart**	**Yes ☐**	**No ☐**
• **Prescribed rescue medication**	**Yes ☐**	**No ☐**
• **Epipen**	**Yes ☐**	**No ☐**
• **Diabetic**	**Yes ☐**	**No ☐**

• **Asthmatic**	**Yes ☐**	**No ☐**

5. Elimination

• **Use of Toilet**	**Yes ☐**	**No ☐**
• **Wears incontinence pad**	**Yes ☐**	**No ☐**
• **Scale on Bristol Stool Chart**	**Yes ☐**	**No ☐**
• **C.Diff**	**Yes ☐**	**No ☐**
• **Bowel Surgery**	**Yes ☐**	**No ☐**
• **Urinary issues**	**Yes ☐**	**No ☐**
• **Catheterisation**	**Yes ☐**	**No ☐**

6. Personal Hygiene

• **Toilet Trained**	**Yes ☐**	**No ☐**
• **Shower/hygiene programme**	**Yes ☐**	**No ☐**
• **Teeth brushing**	**Yes ☐**	**No ☐**
• **Skin conditions**	**Yes ☐**	**No ☐**

• **Menstruation**	**Yes** ☐	**No** ☐
• **Dressing**	**Yes** ☐	**No** ☐

7. Mobility

• **Ambulant/ non ambulant**	**Yes** ☐	**No** ☐
• **Wheelchair dependent**	**Yes** ☐	**No** ☐
• **Use of splints**	**Yes** ☐	**No** ☐
• **Physiotherapy Programme**	**Yes** ☐	**No** ☐
• **Use of Hoist**	**Yes** ☐	**No** ☐

8. Sleeping

• **Use of Oxygen**	**Yes** ☐	**No** ☐
• **Use of CPAP**	**Yes** ☐	**No** ☐
• **Use of sleep system**	**Yes** ☐	**No** ☐
• **Use of Pulse Oximeter**	**Yes** ☐	**No** ☐

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9. Maintaining a safe environment

• **Needs safe environment maintained at all times**	**Yes ☐** **No ☐**

10. Controlling Body Temperature

	Comment
• **Temperature range**	_____
• **Any other issues**	_____

We the School Nurses, thank you for your time in filling out this information for us. If you have any questions or wish to arrange a nurse to assist you with filling out this form please do not hesitate to contact us on 053-9239150.

Please ensure you return this document to the School along with prescription chart filled out by your GP for any medications your child will receive in School daily or as when required such as running a temperature or experiencing pain. Please see a sample prescription chart to guide you and your G.P of how the prescription chart should be written.

Yours Faithfully,

_____ _____

Tina Canavan *Edel Doyle*
School Nurse *School Nurse*

Please tick the appropriate boxes and sign once you have returned same:

- **Medical Information Form ☐**
- **Completed Prescription Chart ☐**

Signed Parent: _____