



EF ACADEMY

Medical Declaration UK

All information will be treated confidentially and will only be shared with health professionals, EF Academy staff or host families, to inform health decisions and to ensure the safety of your child. Information disclosed will not affect your child's application to join EF Academy and will not be used for any other purpose than that stated. This form is to be completed by the parents or guardians of the student. Please ensure that you complete ALL Sections of this form.

Student personal data

Family Name:	First Name(s):
Date of Birth (dd/mm/yyyy):	Gender:
EU/EEA/Swiss Students:	European Health Insurance Number (EHIC) Number:
Student Visa:	Immigration Health (IHC) Number:

1. General health

Has your child ever suffered from any of the following? Please indicate "Yes" or "No"

	Yes	No		Yes	No		Yes	No
Asthama*			Hepatitis (Type)			Measles		
Appendicitis			Tuberculosis			Pneumonia		
Allergies			Eczema			Rubella		
Diabetes			Respiratory Condition			Scarlet Fever		
Epilepsy			Heart Disease			Polycystic Ovary Syndrome		
Migraine			Autoimmune Disease			Other		

If "Yes" to any of the above, please provide details of any ongoing medical treatments, including medicines that have been prescribed to your child:

Describe the impact of the above on your child's ability to study and learn:

2. School emergency salbutamol inhaler

- Has your child shown symptoms of asthma/having an asthma attack? Yes No
If "Yes" please clarify your consent to the following:
- a. I can confirm that my child has been diagnosed with asthma/has been prescribed an inhaler. Yes No
- b. My child has a working, in-date reliever inhaler, clearly labeled with their name, which they will bring to school every day. Yes No
- c. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies. Yes No

3. Dental Health

- Has your child been subject to any major dental or orthodontic treatments in the last two years? Yes No
(other than routine dental procedures)
If yes, please give details:

Has your child had a routine check-up with a dentist or orthodontist in the last 12 months? Yes No

4. Allergies

- Does your child suffer from any allergies? Yes No
If yes, please give details of allergies and treatment (This would include allergic complaints such as hay fever, food allergies, anaphylaxis, allergy to penicillin, etc.):

Does your child carry an adrenaline auto injector such as an EpiPen? Yes No

School Emergency Adrenaline Auto Injector (EpiPen)

- Has your child shown symptoms of anaphylaxis/having an anaphylactic reaction? If yes, please clarify your consent to the following: Yes No
- a. I can confirm that my child has been diagnosed with a severe allergy and has been prescribed an adrenaline auto injector, such as an EpiPen. Yes No
- b. My child has a working, in-date auto injector, clearly labeled with their name, which they will bring to school every day. Yes No
- c. In the event of my child displaying symptoms of an anaphylactic allergic reaction, and if their auto injector (EpiPen) is not available or is unusable, I consent for my child to receive emergency Adrenaline 0.3mg or 0.5mg Yes No

5. Mental and emotional health

Has your child received any form of treatment for mental or emotional health conditions? Yes No

If yes, please give details (This could include current or previous histories of anxiety, stress-related illness, emotional or mental conditions, eating disorder, self harm):

6. Hearing

Does your child require assistance with hearing? Yes No

Has your child ever suffered from deafness, frequent ear infections or discharges? Yes No

If yes, please give details:

7. Eyesight

Does your child normally wear spectacles? Yes No

Does your child normally wear contact lenses? Yes No

Has your child been diagnosed with any visual impairment? Yes No

If yes, please give details:

Has your child had a routine check-up with an optician in the last 12 months? Yes No

8. Special educational needs

Has your child ever been assessed by an educational psychologist or other medical person with regards to additional learning needs or support for school work? Yes No

If yes, please give details:

Has your child ever been diagnosed with one or more of the following conditions:

Dyslexia
Dyscalculia
Dyspraxia

Attention Deficit Hyperactivity Disorder (ADHD)
Specific Learning Difficulties

My child has not been diagnosed with any of these

If Yes, please give details below

9. Medication

a. Is your child currently taking any prescription medication, including controlled drugs , over the counter medicines, such as homely remedies, vitamins, or supplements? Yes No

If Yes, please state the name, strength, dosage and frequency of dosage and the reason why they are being used:

Medication Name	Dosage	Times	Reason for Taking Medication	Prescribing Physician if prescribed medicine

b. Is your child currently taking any medicines that are classified as controlled substances/drugs? Yes No

c. Do you give permission for the school to administer homely remedies such as (tick where appropriate)

Antihistamine	Yes	Ibuprofen	Yes	Throat Lozenges	Yes	Dextrose Tablets	Yes
Paracetamol	Yes	Lemsip (or equivalent)	Yes	Dioralyte	Yes		

d. Do you give permission for your child to visit a pharmacy and buy over-the-counter homely remedies? Yes No

e. Do you give permission for your child to self-administer homely remedies? Yes No

f. Do you consent to your child self-administering all prescribed medication (long-term, short-term, or as needed), including those prescribed in their home country and within the United Kingdom, if different. Yes No

g. Do you consent to EF Academy staff providing medication to your child if deemed unsuitable for self-administration, both prescribed in the UK or home country? Yes No

Please note that the school will never administer non-prescription medicines without agreed consent .

To ensure safety, we kindly ask that home remedies not be brought from abroad. If needed, please source a UK alternative so we can properly monitor their use. EF Academy cannot be responsible for the safe use of home remedies brought in from abroad.

10. Vaccination history

Please complete where applicable. If no vaccines have been given, you acknowledge the risks of infection run by entering an entirely un- vaccinated child into the school, and that a prolonged illness could result in your child needing to return home for treatment.

Immunization	Usual age for immunization	When given
BCG	Birth	
1st DTP, HiB, Polio	8 weeks	
1st pneumococcal	8 weeks	
2nd DTP, HiB, Polio	12 weeks	
1st Meningitis C	12 weeks	
3rd DTP, HiB, Polio	16 weeks	
2nd Meningitis C	16 weeks	
2nd pneumococcal	16 weeks	
4th HiB/3rd Meningitis C	12 months	
MMR	13-15 months	
3rd pneumococcal	13-15 months	
Pre-school booster (DTaP/Polio, MMR2)	4-5 years	
Single Meningitis C	Various, as a catch-up	

11. Medical Release

Medical release – To be filled out by the parents or guardian:

We certify that the records above are complete and accurate. We realise that any misstated or omitted information regarding our son/daughter’s medical/psychological history may affect his or her acceptance to, or continued participation in EF Academy programs. Should there be any new developments in our child’s medical or mental health after the submission of this form and prior to departure, we agree to inform EF Academy immediately. Failure to comply with these requirements may also affect his or her acceptance to, or continued attendance in EF Academy.

We hereby give our full consent for our son/daughter to receive any medical/mental treatment or to undergo any emergency operation which is determined by a medical/mental health professional and may become necessary during his/her stay abroad. Where clinically necessary, relevant medical information may be shared with designated staff or external healthcare professionals to ensure appropriate care and safeguard the student’s and or others health and wellbeing. This will be done on a need-to-know basis, in accordance with UK GDPR, the Data Protection Act 2018, and professional confidentiality standards. Efforts will be made to involve the student and obtain their consent unless doing so would pose a risk, or be impractical due to urgency. For students under 18, parents or guardians may also be informed, where appropriate.

Dispensing Of Medication – Parents Please Read:

We accept full responsibility for any medical expenses for our son/daughter which are not covered by private policy or the NHS. If the undersigned parent / guardian consents to EF Academy’s staff administering prescription, or non-prescription medications the following **must apply**:

Medication will be administered in line with UK law, Royal College of Nursing (RCN) guidance, and the NMC Code. All prescribed medicines must be UK-licensed, clearly labelled in English with the student’s name, dosage, and prescribing practitioner details with a letter explaining medical care needed.

Students will generally be referred to a UK GP for prescriptions. Where this is not possible, foreign prescriptions must be officially translated into English and include full medical details (medication name, dosage, route, indication, and prescriber). Off-label or unlicensed medications will not be accepted or administered on campus.

These requirements apply to both staff- and self-administered medication. Written consent is required from parents/guardians, and from students aged 16+ where appropriate.

Mother / Father / Legal Guardian Name

Mother / Father / Legal Guardian Name

Student Name (Students aged 18 and over only)

Signature

Signature

Signature (Students aged 18 and over only)

Place / Date

Place / Date

Place / Date



EF ACADEMY

EF Academy Oxford – Self Administration of Prescribed Medication

Medication Administration Policy:

- Only listed prescribed medications may be self-administered.
- All medications must comply with section 11 in the Medical declaration
- Medication must remain in original labelled packaging.
- Student must use medication responsibly as a directed by prescribing clinician.
- Student will report all administration errors or omissions.
- Medications must be stored securely unless permitted otherwise.
- The student can evidence what the medication is used for and how to take the listed medications as per prescription.

Sharing medication is strictly prohibited, non-compliance may result in revoked privileges.

Medication Name	Dosage	Times / Schedule	Prescribing Physician	Physician Contact Details

Consent & Agreement:

I hereby give permission for my child to carry and administer the medication outlined above when necessary. I confirm that my child understands the purpose of this medication and knows when and how to self-administer it. Please note, EF Academy is not liable for any errors or issues related to the administration of this medication.

in the event that my son/daughter is unable or deemed unsafe to self-administer I give consent to the school nurse or boarding team to administer listed medications. Yes No

Parent/Guardian Name: Signature: Date:

Student Name: Signature: Date:



EF ACADEMY

EF Academy Oxford – Staff Administration of Prescribed Medication

Medication Administration Policy:

- EF Academy staff will administer only listed prescribed medications.
- All medications must comply with section 11 in the Medical declaration
- Medication must remain in original labelled packaging.
- Medication will be stored securely and administered per physician instructions.
- Parents/guardians must notify the school of any changes to medication.
- The school is not liable for adverse reactions when administered as directed.

Medication Details (Complete for each medication prescribed):

Medication Name	Dosage	Times / Schedule	Prescribing Physician	Physician Contact Details

Consent & Agreement:

I, the undersigned, give permission for EF Academy staff to administer the listed medication to my child as prescribed. I acknowledge responsibility for informing the school of any medication changes and release EF Academy from liability for adverse effects.

Parent/Guardian

Name:

Signature:

Date:

Student (Optional)

Name:

Signature:

Date:

***This form must be renewed annually or upon medication/dosage changes.**