

 **Medical Information Form**

Please complete this medical information form and any necessary additional forms. Please note that it is your responsibility to inform the school if any of this information changes.

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| --- | --- |
| **Name of Child:** |       |
| **Date of Birth:** |       | **Year group:** |       |
| **Name of Medical Centre:** |       |
| **Address of Medical Centre:** |       |
| **Name of Specialist/consultant (if applicable)** |       |

1. **Does your child suffer from any of the following conditions? Please tick as appropriate**

Epilepsy [ ]  Bronchitis [ ]

Chest Problems [ ]  Diabetes [ ]

Fainting [ ]  Migraine [ ]

Heart Trouble [ ]

If you have ticked any of the above conditions, please provide more details below:

1. **Does your child suffer from Asthma? Yes** **[ ]  No** **[ ]**

If YES Please provide details on the Asthma form provided

1. **Will your child be required to take a prescribed medicine in school?**  **Yes [ ]  No [ ]**

If ‘YES’, please provide details on the medication form provided:

1. **Does your child suffer from any allergies (e.g. Penicillin), insect bites or food? Yes [ ]  No [ ]**

If ‘YES’, please provide details on the allergy form provided

1. **If there any other medical issues that you feel you need to make school aware of please state below.**

**Declaration By Parent/Carer**

* In the case of an emergency I agree to my child being given any medical, surgical or dental treatment, including general anaesthetic and blood transfusion, as considered necessary by the medical authorities present.
* I will ensure that any change in the circumstances (e.g. recent illness, medication or injury) will be communicated to the school.

Signature of parent/carer (typed):

Print Name:

Date:

Emergency contact name:

Emergency contact number:

Relationship to child: