**Medical Information
Please complete all the sections below:**

**Student’s Name: …………………………………………………………………………………………… Year Group: ………………………**

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| **Name and address of GP/Doctor**:**Telephone No**: |
| **Does your child suffer from any of the following medical conditions? Please tick all that apply and how serious the condition is**:Asthma **Is the condition** Mild Moderate SeriousDiabetes **Is the condition** Mild Moderate SeriousHeart condition **Is the condition** Mild Moderate SeriousEpilepsy **Is the condition** Mild Moderate SeriousFainting/Blackouts **Is the condition** Mild Moderate SeriousADHD **Is the condition**  Mild Moderate Serious**Other condition**: ……………………………………….. **Is the condition** Mild Moderate Serious |
| **Will your child need to take any medication in school for any of the medical conditions stated? If so, please explain what is required:**Name of medication**:** …………………………………………………………………………………………………………………………………………………………..When will the medication be taken? …………………………………………………………………………………………………………………………………….Other information about the medication: ……………………………………………………………………………………………………………………………. |
| **Does your child have an allergy?** **YES NO** **If yes,** what is your child allergic to**? …………………………………………………………………………………………………………………………..**Please tick whether the reaction is**:** Mild Moderate SeriousDoes your child need medication for the reaction?  **YES NO****If yes, please explain what is needed:** ……………………………………………………………………………………………………………………………….………………………………………………………………………………………………………………………………………………………………………………………….. |
| **Is there anything else about your child’s medical history that we should know?** |
| **Signed:**  ……………………………………………………………………………………………………….. **Date:** ……………………………………………………………… (Parent/Guardian) |