**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 Serious  Diabetes **Is the condition** Mild Moderate Serious  Heart condition **Is the condition** Mild Moderate Serious  Epilepsy **Is the condition** Mild Moderate Serious  Fainting/Blackouts **Is the condition** Mild Moderate Serious  ADHD **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 Serious  Does 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) |