MEDICAL FORM

CHILD’S NAME

______________________________

Doctor’s Name and Address

______________________________

Does your child attend any Hospitals? If so, please give the name of the consultant and the Hospital.

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1. Please indicate below if your child has any medical condition which may affect him/her at school and give details

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2. Please give details of any medication which may need to be administered during the school day on a regular OR emergency basis.

______________________________

3. Does your child suffer from any allergy? If yes, please give details

______________________________
4. Does your child have any special dietary requirement? If yes, please give details below

5. Does your child wear glasses? Yes [ ] No [ ]

   Does your child have a hearing problem? Yes [ ] No [ ]

6. Do you have any concerns about your child?
7. Please give details below.

I consent to any emergency treatment during the school day and understand my child’s details will be shared with all relevant parties where necessary in accordance with the new Data Protection ruling (GDPR).

Signed Parent/Carer: ________________________________________________