

**HEALTH/MEDICAL INFORMATION**

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| **Details of the Student’s GP** |
| GP Name |
| Surgery Address |
| Post Code | Telephone number |
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| **Details of any other Clinic/Hospital/Agency involved: (eg Community paediatrician, specialist consultants)** |
| Named contact | Clinic/Hospital/Agency | Telephone number |
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| **In the event of my child requiring emergency treatment** and the Head Teacher (or his/her representative) being unable to contact me , I give consent for the member of staff accompanying my child to approve the application of emergency treatment, including anaesthetic, advised by the medical authorities for the wellbeing of my child.I give consent for my child to receive emergency medical treatment *(Please tick)* |
| **Yes** | **No** |
|  |  |
| Signature | Date |
| Parent/Carer Name |

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| **Student’s Medical condition** |
| **Is it an ongoing condition?** (*Please tick)* | **YES** | **NO** |
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| **Please list all medication that your child is currently taking, including emergency medicines** |
| Medication | Dosage |
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| **Students condition and individual symptoms** |
| **Daily care requirements** |
| **Procedures to take in an emergency** |
| **Any allergies, including food allergies**  |
| **Additional information (if needed)**  |
| Using the information provided we will create a long term care plan for your child. We will let you know when this is ready to be reviewed and authorised by you. |
|  |
| Signature | Date |
| Parent/Carer Name |