

**HEALTH/MEDICAL INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details of the Student’s GP** | | | | |
| GP Name | | | | |
| Surgery Address | | | | |
| Post Code | Telephone number | | | |
|  |  | | | |
| **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** |
|  | |  | |  |
| **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 | | | | |