MEDICAL INFORMATION FORM

This information will only be shared as appropriate and on a need to know basis.

Students Name	
Date of Birth	
NHS Number	
Home Address	
Telephone Number	

HEALTH QUESTIONNAIRE (This must be completed and signed)
Does your child now have or has ever experienced any of the following (please tick all that apply):

- ☐ Diabetes
- ☐ Chest Pains
- ☐ Muscular/Joint problems
- ☐ **Diagnosed** Asthma
- ☐ Other respiratory problems
- ☐ Migraine/Dizziness
- ☐ Recent Surgeries
- ☐ Any sustained injuries/illnesses
- ☐ Epilepsy
- ☐ Difficulty with any form of physical exercise
- ☐ Currently taking any medication
- ☐ Severe allergic reaction
- ☐ Other

If you ticked any of the above, please give details of the condition below:

Does your child require any prescribed medication during the school day?	Yes/No (If yes, please give further details of the medication and the frequency. You will also need to complete a prescribing medication form which are available through the School Office)

Could your child's condition ever require additional or emergency medical attention in school?	Yes/No (If yes, please give further details below)

Please note that any medication held by School for students must be prescribed by a Doctor, in the original container and clearly marked with the child's name. Parents must ensure medication is in date and in school. Parents will have to sign the medication form and also need to dispose of medication after the prescribing period is complete.

It is the responsibility of the parent/guardian to inform the school of any changes to the above information whether temporary or permanent.

I, as the parent/guardian of the above student admit to the information given as being true and correct and take full responsibility for any incident arising where information has been withheld.

Signed: …… Date: …….
(Parent/Guardian)

Print Name: …….. Relationship to Student: ……..