Oxspring Primary School

MEDICAL INFORMATION FORM

CONFIDENTIAL

Child's Name:	Date of Birth:

Details of person completing this form

Full Name:		
Relationship to child:	Parental Responsibility? **YES / NO**	
Home Address: Post Code:		
Is the child resident at this address? **YES / NO** *(please delete as appropriate)*		
Home telephone:	Mobile:	Day/Work telephone:

Medical Information

Doctor(s):
Doctor's address:
Doctor's telephone number:
Medical Conditions Does your child have any medical conditions which school needs to know about. If so, please provide brief details:
Does your child take medication? YES / NO (delete as applicable) If yes, please list the medication(s) and confirm whether it / they will need to be administered in school hours and *complete the Administration of Medication form available from school reception*.
Does your child use an inhaler? YES / NO (delete as applicable) If yes, will it need to be used in school hours? YES / NO
Do we have your permission to put a plaster on your child if appropriate to do so? YES / NO (delete as applicable)
Does your child have any food allergies / dietary needs? YES / NO (delete as applicable) If yes, please detail below

Medical diagnosis / ongoing investigation (if relevant)	**√** as appropriate
I have provided school a copy of correspondence relating to my child	
I have not provided school a copy of correspondence relating to my child	
Any other details:	

Signature:	Date: