SHEVINGTON VALE COUNTY PRIMARY SCHOOL

MEDICAL FORM

NAME OF CHILD ..... D O B .....

ADDRESS ..... TEL NO .....

.....

EMERGENCY TEL NO .....

CHILD'S DOCTOR ..... TEL NO .....

ADDRESS .....

1. Is your child receiving medical treatment at present? YES/NO

2. Has your child been in contact with an infectious/contagious illness recently?

   YES/NO .....

3. Does your child suffer from:

Epilepsy	YES/NO
Asthma	YES/NO
Hay Fever	YES/NO
Enuresis (Bedwetting)	YES/NO
Diabetes	YES/NO
Foot Infection (verucca)	YES/NO
Heart Condition	YES/NO
Physical Disability	YES/NO
Visual/Hearing Impairment	YES/NO

4. Has your child had any serious illness during the last 3 months? YES/NO

5. Are there any restrictions on physical activity in school? YES/NO

6. Has your child any special dietary requirements? YES/NO

7. Is your child allergic to any drugs and/ or plasters ? YES/NO
   If yes please provide details:

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8. When did your child last have an anti-tetanus injection? .....

9. Is there anything else we need to know about your child's health ?

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I declare that I have answered all the above questions honestly and have not knowingly withheld any important information regarding physical fitness

I GIVE / DO NOT GIVE (delete as appropriate) permission for my child to be given anaesthetic in case of emergency - I understand that in the event of need for hospital treatment due to illness or accident, if I cannot be contacted then a member of teaching staff will take responsibility for appropriate consent (eg use of anaesthetic)

I GIVE / DO NOT GIVE (delete as appropriate) permission for my child to be given appropriate pain/flu/cough relief eg. Paracetomol, Benylin, Calpol etc.

Are there any specific medicines that should not be given? YES/NO

If you do not wish your child to appear on photos taken by Centre Staff during the visit please tick this box ☐

Signed ..... Parent/Guardian Date .....