



PUPIL MEDICAL INFORMATION

Please attached an up-to-date photo of
your child here

Child's Name:

Date of birth:

Address:

Parent's Name:

Parent's Contact Number:

Doctor:

I request that a member of staff administers the required medication/s listed to my child as described in the following documents. However, if for any reason the medicine fails to be administered, I understand that the school cannot be held responsible.

I agree to update the school if there are any changes in my child's medical needs.

I will ensure that the medicine held by the school has not exceeded its expiry date.

I have read and understood the school's Medicine Policy.

PARENT SIGNATURE: **DATE:**

Please complete each section of the Medical Information Form that applies to your child.

(Tick as applies)

Asthma

Allergies

Regular medications



ASTHMA

I can confirm that my child has been *(please tick)*:

1. Diagnosed with Asthma YES NO

2. Prescribed an inhaler YES NO

3. Other *(please describe)*:

What **signs** indicate your child is having an asthma attack?

.....

What are your child's **triggers** *(things that make their asthma worse)*?

.....

.....

Does your child require medication for asthma? YES NO

Name of medication:

Dosage: Expiry date:

Does your child tell you when they need medicine? Y/N	Does your child need help taking their medicine? Y/N	Does your child need to take medicine before exercise or play time? Y/N <i>(please describe)</i>	Is your child likely to experience any side effects when taking medication? Y/N <i>(please describe)</i>

I confirm that we will provide a working, in-date inhaler, clearly labelled with my child's name to be kept in my child's classroom:

YES NO

In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive SALBUTAMOL from an emergency inhaler held by the school:

YES NO

PARENT SIGNATURE: **DATE:**



ALLERGIES

I can confirm that my child is allergic to and must not come into contact / ingest the following:
(please list all)

.....
.....

Please tick all the symptoms that apply:

Mild symptoms	Severe symptoms
<input type="checkbox"/> Nose – itchy runny sneezing <input type="checkbox"/> Mouth – itchy <input type="checkbox"/> Skin – a few hives/mild itch <input type="checkbox"/> Gut – mild nausea/discomfort	<input type="checkbox"/> Lung – short of breath, wheezing, repetitive cough <input type="checkbox"/> Heart – pale, blue, faint, weak pulse, dizzy <input type="checkbox"/> Throat – tight, hoarse, trouble breathing/swallowing <input type="checkbox"/> Mouth –significant swelling of the tongue and or lips <input type="checkbox"/> Skin – many hives over body/widespread <input type="checkbox"/> Gut – vomiting/diarrhoea <input type="checkbox"/> Other – feeling something bad is about to happen

Please describe any other symptoms:

.....

In the event of my child displaying symptoms of an allergic reaction, please provide details of the treatment plan:

.....

Does your child require medication/s? YES NO

(If yes, you will also need to complete the Pupil Medication Request Form on page 4)

Name of medication/s:

Dosage: Expiry date:

Is your child likely to experience any side effects when taking any of these medicines? YES NO

If yes, please describe:

.....

.....

REMINDER: HAVE YOU FILLED OUT A TWELVE15 SPECIAL DIET REQUEST FORM?



Pupil Medication Request

Child's Name: Class:

Parent Contact Number:

Name of medicine: Dosage:

Time that Medicine should be administered:

Dates that medicine should be administered:

From: To: Total number of days:

Is your child likely to experience any side effects whilst taking this medicine?

YES NO

If yes, please provide further details:

.....
.....

Does medicine need to be given to After School Club at the end of the day?

YES NO

I request that a member of staff administers medicine to my child and will contact the school at the time at which this medicine is due to be administered. However, if for any reason the medicine fails to be administered, I understand that the school cannot be held responsible.

I will ensure that the medicine held by the school has not exceeded its expiry date.

I have read the school's Medicine Policy.

PARENT SIGNATURE: **DATE:**

TO BE COMPLETED BY STAFF MEMBER GIVING MEDICINE:

<u>Date & Time Given</u>	<u>Dosage</u>	<u>Signature</u>