PLEASE COMPLETE BOTH SIDES

WARNHAM CE PRIMARY SCHOOL

Contact details and medical information

Please note that we will keep these contact and medical details on file during the child's time at school and use them as necessary (including emergency situations) when your child is on any school trip. If there are any changes it is parents' responsibility to ensure that the school office is notified as soon as possible.

Child's Full Name: ____

Home Address: ____

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Child's Date of Birth: ____

Parent/Guardian's Full Name: ____

Home Address (if different from above): ____

____

Telephone numbers: Home ______________________ Work ____________________________

Mobiles ____

Please state an alternative contact in case you are unavailable.

Name: ____

Address: ____

Telephone numbers: Home ______________________ Work ____________________________

Mobiles ____

MEDICAL INFORMATION

Details of Family Doctor

Name of Surgery: ____

Address: ____

Phone Number: ____

Cont'd overleaf

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Has your child had any of the following:	Yes	No
Asthma or Bronchitis		
Heart condition		
Fits, fainting or blackouts		
Severe headaches		
Diabetes		
Allergies to any known drugs or medication		
Any other allergies e.g. material, food, insect bites etc		
Other illness or disability		
Any recent contact with contagious diseases and infections		

If the answer to any of these questions is YES please give details on a separate sheet which should be firmly attached (including details of medical treatment required)

	Yes	No
Is your child receiving medical treatment of any kind from either your Family Doctor or Hospital?		
Has your child been given specific medical advice to follow in emergencies?		

If the answer to either of these questions is YES please give the details here. (This should include dosage of any medicines/tablets. Prescribed medication should be in its original container or packaging and accompanied by written instruction for its administration.)

	Yes	No
Has your child received vaccination against Tetanus in the last ten years?		

Ad-Hoc medicine	Yes	No
Please indicate if your child can have either of the medicines if needed. (we will always phone you first)		
Paracetamol		
Anti-histamine		

Please give details of any special dietary requirements ___________________________________

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DECLARATION

I believe that the details provided above are correct and will notify the school of any changes as soon as possible. I agree to my child receiving medication as instructed and to any emergency dental, medical or surgical treatment as considered necessary by the medical authorities present.

Signed _____________________________________ Parent/Guardian Date ________________