



St John's R.C. Primary School

MEDICAL FORM

(Please complete if your child has a medical condition or allergy)

Pupil's Name _____

Date of Birth _____ **Male/Female** _____ **Class** _____

Medical condition (asthma, eczema, allergy, epilepsy etc.)

NHS No. _____

This MUST be completed in the event of your child being taken to hospital

GP _____ **Telephone no.** _____

Name of medication _____

Dosage/method _____ **Timing** _____

Describe condition and give details of pupil's individual symptoms

Self-administration Yes/No

All medication kept in school must be clearly labelled with pupils name and dosage

Describe what constitutes an emergency for the pupil, and the action to be taken

Contact Details – Mother / Father

Name _____ **Telephone No.** _____

