South Lee Annual Medical Form

Date: ____

Pupil Name: ____

Date of Birth: __________________________________ Class: ______________________________

This form is for the guidance of the school. The information you provide will be kept on the pupil's record. Key information will also be accessible to members of staff on a 'need to know' basis, in the interests of your child's safety and wellbeing. Staff are in loco parentis when caring for your child, therefore it is important to include all relevant information here. If you wish to discuss any issues confidentially, please feel free to contact the school nurse directly (tel: 01284 754 654 or email: d.macfarlane@southlee.co.uk).

EMERGENCY CONTACT DETAILS

Please provide contact details to be used in case of emergency.

Name: ____ Contact Number: __________________________________

Name: ____ Contact Number: __________________________________

Allergy Information

Please list any allergies to food, medication, insect stings or any other substances. Please tell us what happens if your child does come into contact with this substance. For example rashes or swelling, and if any intervention is required.

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Ongoing Medical Issues

Please document any important medical diagnoses your child may have. For example: Diabetes, Asthma, Epilepsy, Eczema. When necessary, we will complete a Health Care Plan, which will be sent to you for comments and a signature.

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Medication

Please detail your child's current prescription medication, including inhalers/ointments.

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Any Other Health Concerns

For example: Vision/Hearing/Mental Health/ Dental/Bed Wetting.

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Is your child up-to-date with Tetanus vaccinations?	Name, address and telephone number of Pupil's GP:
Yes ☐ No ☐	…………………………………………………………………………
	…………………………………………………………………………
Date of vaccination: …………………………………	…………………………………………………………………………

Medical Consent

- I give consent for the nurse/first aid trained staff to treat injuries or illness — Yes ☐ No ☐
- I give consent for the School Nurse to administer over the counter medication as required. — Yes ☐ No ☐

Over the counter medication available to be dispensed by the nurse:

Analgesia/Pain Relief	Anti-Histamines/Allergy Relief	Creams/Ointments
Paracetamol Tablets	Piriton Tablets	E45 Dry Skin Relief
Paracetamol Syrup	Piriton Syrup	Waspeze
Sugar Free Calpol	Cetirizine Tablets	Anti-Histamine Cream

I understand that I must notify the school immediately of any changes in writing.

Signature: ……………………………………………………………………………

Date: ……………………………………………………………………………

Name of Parent/Guardian (in block capitals):

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