**CONFIDENTIAL MEDICAL INFORMATION**

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| Name of Pupil |  |
| Date of Birth |  |

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| PLEASE LIST ANY FOOD OR DRINK THAT YOUR CHILD CANNOT TAKE:  (*this section relates to allergies, not food disliked by your child)* |
| PLEASE IDENTIFY ANY KNOWN ALLERGIES AND TREATMENT REQUIRED: |
| PLEASE LIST ANY CURRENT MEDICATION AND PURPOSE |
| PLEASE DETAIL MEDICATION TO BE HELD IN SCHOOL AND DATES PROVIDED  (*it is essential that all medication is held in the school office and it is parents’ responsibility to ensure that it has not gone beyond the USE BY date; a consent form has to be completed at the school office if you require the school to keep medication/administer medication to your child)* |
| PLEASE USE THIS SECTION TO INFORM THE SCHOOL OF CONCERNS OR MATTERS YOU WISH US TO BE AWARE OF(*all information is treated confidentially and sympathetically, continue overleaf if necessary*). |

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| **Signature** |  |
| **Print Name** |  |
| **Relationship to Child** |  |
| **Date** |  |