



PUPIL MEDICAL RECORD

Surname.....

Forename

Date of Birth

Class

Doctor's Name and Address

.....

Does your child have any on - going medical condition? If so, please describe the condition(s):

.....

.....

Does your child need to take medicine regularly?

Please advise regarding dosage and frequency.....

.....

Do you wish to see staff to discuss your child's medical needs? Yes / No

A care plan will be drawn up around your child, if it is deemed necessary. You will be asked to give permission for the administration of medicine.

I have included all current medical conditions concerning my child.

Signed

Date.....