



MEDICAL INFORMATION AND CONSENT FORM

Student Information

Surname: _____ First Name: _____

Address: _____

_____ Postcode: _____

Date of Birth: _____ NHS Number: _____

Emergency Contact Details:

Please provide details of two persons who are to be contacted in an emergency

Contact Details – Priority 1

Title: _____

Surname: _____

First Name: _____

Relationship to student: _____

Daytime Number: _____

Mobile: _____

Work Phone: _____

Home Phone: _____

Contact Details – Priority 2

Title: _____

Surname: _____

First Name: _____

Relationship to student: _____

Daytime Number: _____

Mobile: _____

Work Phone: _____

Home Phone: _____

Medical Information

Medical Practice: _____

Address: _____

_____ Post Code: _____

Telephone Number: _____

Name of Doctor: _____

Medical Questions – *(Please tick appropriate box)*

Does your daughter have any dietary requirements? (if yes please provide details) [] Yes [] No

Does your daughter have any allergies? (if yes, please provide details) [] Yes [] No

Does your daughter have a medical condition the school should know about? (if yes, please provide details)
[] Yes [] No

Has your daughter had her pre – school booster including tetanus? (if yes, please provide details) [] Yes [] No

Personal health plan

Should there be any further information relating to your daughters health, you think we should be aware of, please provide details below, also please give any instructions that you wish us to follow in case of a medical emergency

Consent

If treatment is required, I hereby give permission for the staff in charge, to act in loco parentis

Name of Parent / Guardian (please print) _____

Signature: _____

Date: _____