Medical conditions

PART 1 – ALLERGIES

As you are probably already aware, severe allergic reactions are life threatening and can be completely unexpected. Please help us to care for your child by completing and returning this form to the school office without delay.

Name of child: _____ Class: _____

Does your child have any kind of allergy/allergies: Yes/No (please circle as appropriate)

If your child suffers from an allergy, please provide full details below:

1. What allergy does your child have?
   _____
   _____
   _____
2. What are the symptoms they may experience?
   _____
   _____
   _____
3. Is he/she on any form of medication for the allergy? **Yes/No (please circle as appropriate)**
4. If yes, please list:
   _____
   _____
   _____
5. In which case would they need the administration of the medication?
   _____
   _____
   _____

PART 2 – MEDICAL HISTORY:

Does your child have a medical condition: Yes/No (please circle as appropriate)

Please provide your child's full medical history below:

Section A- Medical History Please use this section to outline any medical history your child may have experienced

Section B- Current Medical Condition Please use this section to outline any medical conditions your child may have
Section C- Current Medication If your child is currently on permanent medication and they would be required to have their medication during school hours, please provide details of the medication, time of the day the medication would need to be administered e.g. asthma inhalers

Signature of Parent / Guardian _____Date_____