HEALTH AND SAFETY

DETAILED MEDICAL INFORMATION SHEET

NAME _____ **DOB**_____

ADDRESS_____

_____

PARENTS NAME(S)_____

Contact 1 _____ **Tel no**_____

Contact 2 _____ **Tel no**_____

Contact 3 _____ **Tel no**_____

Contact 4 _____ **Tel no** _____

GPs NAME_____ **Tel no**_____

Consultant _____

CONDITION_____

_____

_____

First Diagnosed _____

How often does the condition occur _____

Last known incident _____

How severe was the incident/attack _____

Medication needed _____

Blood group _____

Do you want the school to

*** Supervise the administration of medication YES / NO**

*** Administer medication YES / NO**

If so answer these questions please

DOSE to be given _____

What times _____

If an incident occurs the TREATMENT to follow would be

_____

_____

_____

If your child was attending an Educational visit would you agree to staff making decisions on your behalf (in consultation with you) and with senior medical advice?

YES / NO signature _____

Any other comments _____

_____

PLEASE CONTACT THE SCHOOL / HEALTH AND SAFETY OFFICER IF THEIR HAS BEEN ANY SIGNIFICANT CHANGE TO YOUR CHILDS MEDICAL NEEDS.

Mr D Hollyman Health and Safety officer