



STUDENT INFORMATION

Name:

Address:

Year Group: Form Group:

Sex: Male Female

D.O.B: DD MM YY

PARENT/CARER CONTACT 1

Name:

Phone No:

Mother Father Step Parent Guardian

Mobile:

PARENT/CARER CONTACT 2

Name:

Phone No:

Mother Father Step Parent Guardian

Mobile:

MEDICINE INFORMATION

- Name/type of medicine (as described on the container):
- Date dispensed:
- Expiry date:
- Dose and method (how much and when taken):
- Special precautions:
- Any side effects that the school needs to know about?
- Self-administration (please tick as appropriate) Yes No

EMERGENCY PROCEDURES

What to do in an emergency:

PARENTAL AGREEMENT*

- I understand that this is a service that the school is not obliged to undertake.
- I UNDERSTAND THAT I MUST NOTIFY THE SCHOOL OF ANY CHANGES IN WRITING.

Signature:

Print Name:

Date:

OFFICE USE ONLY

Date for review:

Copies held by: