MEDICAL INFORMATION SHEET

Name: DOB:

Address:

Contact Telephone Number: Medical condition:

|  |  |
| --- | --- |
| MEDICATION DETAILS | |
| NAME OF DRUG |  |
| DOSAGE |  |
| PREFERRED TIME TO TAKE |  |
| ANY OTHER RELATED INFORMATION |  |
| ANY KNOWN ALLERGIES |  |

|  |  |
| --- | --- |
| EMERGENCY CONTACT DETAILS | |
| NAME |  |
| CONTACT NUMBERS |  |
| RELATIONSHIP TO CHILD |  |

|  |  |
| --- | --- |
| GP DETAILS | |
| SURGERY |  |
| CONTACT NUMBER |  |

|  |
| --- |
| ANY OTHER INFORMATION |
|  |
|  |
|  |
|  |

I give permission for a member of the first aid team to make available the medication for my child to take at the Academy and for any information to be shared with staff in a confidential manner

Name of Student: Signature: