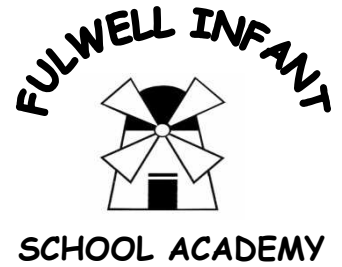


MEDICAL STATEMENT



This statement is for the control and administration of *Prescribed medicine in school* for the academic Year 2015 – 2016

- Allergies (including food allergies), Epilepsy, Diabetes
- Any other physical condition that would have a medical implication on a pupil's full participation in school life.
- *NB : There is a SEPARATE form to be completed for the control of ASTHMA in school*

Name of Child: Date of Birth: Class:

Address:

Medical Condition (please tick)

- Diabetes * Epilepsy *
- Allergy* please specify Epipen

Please note: Only formally diagnosed allergies, where a serious reaction could occur, should be recorded on this statement. You should NOT be recording examples which could be considered 'preference' rather than a genuine medical condition e.g. 'does not like banana' or 'will not eat anything containing milk'

** If your child has a Care Plan from the Doctor or Hospital we **MUST** have a copy for your child's records which we will discuss with you at a pre-arranged appointment*

Daily Medical/care requirements:

Action to be taken in case of emergency

ADMINISTRATION OF ANTIBIOTICS - condition

Medication to be administered

Dosage & Time to be administered

TO BE COMPLETED BY THE PARENT/CARER:

- ✓ I request that my child be given the medication as stated overleaf, which has been prescribed by a registered Medical Practitioner. Where applicable, I will also provide any supporting information from my child's GP of their condition.
- ✓ I confirm that I will supply this medication in the form in which it was supplied to me by the pharmacist. I understand the school will NOT accept any medications that are in unmarked packages and which do not contain the administration details as supplied by the pharmacist.
- ✓ I understand that the medication prescribed should be delivered by me personally to Mrs Boucher/Mrs Gibson in the School Office in the first instance and that this is subject to agreement with the school. I will make arrangements to collect any unused medicine at the end of the school year.

Contact Information in the Event of Emergency:

<i>1st CONTACT</i>	<i>2nd CONTACT</i>
NAME	NAME
ADDRESS	ADDRESS
DAYTIME TEL NO	DAYTIME TEL NO
Mobile No	Mobile No
RELATIONSHIP TO CHILD	RELATIONSHIP TO CHILD
Child's Doctor	
Surgery Address	
Telephone Number	
Any other agency involved in pupil care (Clinic/Hospital/Social Worker)	

NB If you wish to discuss any of the above with either Ms Boucher or Mrs Gibson please contact the school office.. To enable us to discuss your child's condition in more depth these appointments will be arranged prior to or at the end of the school day.

This medical statement will be reviewed on an annual basis in September of each year unless the medical condition changes in which case parents are responsible for informing the school.

Signed:

Relationship to child:

Date:

Signed: Mrs J Boucher, Lead First Aider

Signed: Mrs A Gibson, Business Manager

Signed: Headteacher