Broadbottom CE (VC) Primary School

MEDICAL FORM

Child's Name ....

Class .... DOB ....AGE:....................

Doctor's Name ....

Address ....

....

Phone Number ....

Does your child have asthma? Yes/No

Does your child have an inhaler? Yes/No/NA

***If yes, please complete the attached Asthma Medication Sheet.**

ALLERGIES

Does your child have an allergy? Yes/No

What is your child allergic to? ....

What are the symptoms? ....

What is the treatment? ....

MEDICAL

Glasses	Yes/No	To be worn in school	Yes/No
Hayfever	Yes/No	Hearing impaired	Yes/No
Eczema	Yes/No	Hearing aid	Yes/No

Epilepsy Yes/No ***If yes please complete the attached Epilepsy Form**

Any other (if so give details below)

....

....

Signed:(Parent/Carer) ....Date:...

Please return the completed form and the medication to the school office