

Broadbottom C of E 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)

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.....

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

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