Holy Family Catholic Primary School

MEDICAL FORM

FULL NAME OF PUPIL……..…

DATE OF BIRTH…… CLASS …….

Name, address & telephone number of child's GP
Any medical condition (including wearing spectacles etc)
Medication taken by child
Allergies
Child's specialist (if applicable)
I give permission for staff to administer antibiotics/medication when required **Yes / No (please circle)**

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