CHILD’S NAME …………………………………………………………………….………… DATE OF BIRTH …………….............…………..

Does your child suffer from any of the problems below? If so please give details.

|  |  |
| --- | --- |
| **Condition** | **Details** |
| Vision Problems/Colour Blindness | If your child wears glasses when should they wear them? |
| Ear/Hearing Problems |  |
| Diabetes |  |
| Severe Headaches / Migraines |  |
| Allergies |  |
| Asthma |  |
| Eating / Dietary Problems |  |
| Fits or Convulsions |  |
| Hayfever |  |
| Heart Condition |  |
| Nose Bleeding |  |
| Speech Difficulties |  |

**Please turn over page**

Has your child ever had a serious allergic reaction to anything (e.g. Peanuts, nuts, bee/wasp stings etc.)? If they require an epipen or anti-histamines, please also give details.

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Has your child ever been hospitalised or have any continuous medical treatment / medication? If so please give details.

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Is there any other medical condition that may affect school life? If so please give details.

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I do / do not give permission for a first aid trained member of staff to remove stings or splinters from my child.

**If your child requires medication to be administered at school please visit the School Office for additional forms, so we are prepared for the day your child starts school.**

**SIGNED** ……………………………………………………………………………………………………… **DATE.**……….……………………………..

**PARENTS NAME …………………………………………………………………..………………….**