** Brookfields School Medical Information Form. 2018-2019**

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| Name of child: | Date of Birth: |
| Any previous surname: | Male / Female: |
| Address: | Postcode: |
| Mothers / Carers name:  Address (if different to child): | Home tel no:  Mobile tel no: |
| Fathers / Carers name:  Address (if different to child): | Home tel no:  Mobile tel no: |
| Who has parental responsibility? | |
| Name of schools / settings attended prior to Brookfields: | |
| GP Name and Address: | Dentist Name and Address: |
| Other agencies involved; Please tick and name | Telephone number of the agencies (if known) |
| Speech and Language |  |
| Occupational Therapy |  |
| Physiotherapy |  |
| Orthoptist / Optician |  |
| CAMHS |  |
| Social Care |  |
| Other |  |
|  |  |
| Known Diagnosis: | |
| Medication (please list any taken) | Any emergency medication e.g. Buccal Midazolam |
| Other health issues to note: | Allergies (including food, nuts and medication) |
| Does your child wear glasses? Yes / No | Opticians or hospital based (please delete) |
| Does your child wear a hearing aid? Yes / No | Which clinic? |
| Please list any dietary requirements | |

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| Any additional information that needs to be shared: |

I understand that it is my responsibility to notify school immediately if any of the information I have given changes.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent / Guardian)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information Form 08/18**