

MEDICAL CONDITION OR ALLERGY

*please complete this form for our school records
and return it to the school office as soon as possible*

NAME OF CHILD

ROOM

NAME/S OF PARENTS

CONTACT TELEPHONE NUMBERS

MY CHILD HAS THE FOLLOWING MEDICAL CONDITION OR ALLERGY

**TREATMENT REQUIRED AT SCHOOL
PLEASE GIVE CLEAR, SPECIFIC INSTRUCTIONS**

please continue on back of form if necessary

please tick box if your child requires an asthma inhaler to be kept at school

in school bag

in sickbay cupboard

Date