Child's First Name:_____ Child's Last Name_____ Parent's name _____ Home Address: _____ Current email address: _____ Does your child have any condition, illness or allergy, please give full details: Please provide 3 contact numbers in case of emergency: Relationship to Child Contact Number Name GP Name:_____ GP phone number: _____ GP Address:_____ Should your child need any medication in school, please contact Mrs Southgate to discuss this. Please tick to confirm you have understood the administration of medicines. ☐ My child will be responsible for the self-administration of medicines. I will provide spoons/syringes. Please tick both boxes below: ☐ I agree to update information about the child's medical needs held by the school and that this information will be verified by GP and/or medical Consultant. ☐ I will ensure that the medicine held by the school has not exceeded its expiry date. I understand that medicines will be kept by the adult in my child's group. Signed _____ Date _____ (I have PR for the above named child) Print name _____

Family Information for Children returning to school June 2020 or keyworker children

To be completed by parent						
Name of medicine	Dose	Frequency/ times	Completion dates of course if known/ relevant	Expiry date of medicine		
Special instructions:						
Allergies:						
Other prescribed medicines child takes at home:						

For School Use					
Name of medicine	Dose	Time given	Given by;		