KING DAVID PRIMARY SCHOOL MEDICAL FORM

Surname: **Forename(s):**

Name commonly used: **Class**:

Does your child suffer from asthma?	
If yes, is this controlled by medication?	
If yes, what medication do they take?	
Do they use an inhaler?	
Does your child suffer from diabetes? **If yes, please give details of current treatment.**	
Does your child suffer from any allergies? **If yes, please give details.** **Has any allergy resulted in anaphylactic shock?** **If yes, do they carry an epi-pen?**	
Is your child allergic to plasters?	
Does your child suffer from any other medical condition, e.g. vision impairment, hearing loss, petit mal, etc.? Please give details.	
(Please feel free to write information of a more sensitive nature on a separate letter attached to this form)	
Do you give your consent to your name and address being given on request, to the Local Health Authority to enable them to contact you regarding immunisation programmes?	
Doctor's Name:	**Doctor's Address:**
Doctor's phone number:	

This form will be retained in accordance with current data protection legislation

Signature: _____ Date: _____