

7. Does your child has any allergies?

No Yes If yes please provide details below

8. Has your child ever had a serious illness, hospitalization and / or surgery?

No Yes If yes please provide details below

9. Does your child have any chronic or continuing medical problems?

No Yes If yes please provide details below

10. Is your child on long-term medication?

No Yes If yes please provide details below

11. Are there any of the medicines listed below which you would not want your child to be given should the need arise at school? If yes please tick the box(es).

Paracetamol	<input type="checkbox"/>	Antihistamine cream	<input type="checkbox"/>	Throat lozenges	<input type="checkbox"/>
Antiseptic Cream	<input type="checkbox"/>	Antihistamine tablets	<input type="checkbox"/>	Cough Medicine	<input type="checkbox"/>
Eye drops	<input type="checkbox"/>	Antihistamine Injection	<input type="checkbox"/>		<input type="checkbox"/>

12. Please inform the school of any changes in your child’s health status. The school cannot be held responsible for acting on information, which has not been updated.

13. I give permission for qualified representatives of the school or external medical personnel to administer medical treatment to my child should the need arise.

Signed: _____ Date: _____