Castle Gardens Primary School
Medical Record Form

Pupil's Name: _____ Class:_____

Date of Birth: _____

A. MEDICAL INFORMATION

Please tick any appropriate box and give any details if necessary:

Allergies	☐	Eczema	☐
Asthma	☐	Epilepsy	☐
Cystic Fibrosis	☐	Glasses	☐
Diabetes	☐	Heart condition (give details)	☐
Speech	☐	Mobility	☐
Hearing (left)	☐	Hearing (right)	☐
No medical issues	☐		

Other (detail below):

_____

_____

Please note if any medication is to be administered during school time a REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION form will need to be completed and refreshed at the start of each academic year.
Without completion of this form medication will not be administered.

Class Teacher: _____ Date: _____

Parent/Guardian: _____ Date: _____