



# Woody's Medical information sheet

Child's name: \_\_\_\_\_

Parent/Guardian's surname if different: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Condition or illness: \_\_\_\_\_

Parent/Guardian's telephone numbers:

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

G.P. Name: \_\_\_\_\_ G.P Telephone: \_\_\_\_\_

G.P. Location: \_\_\_\_\_

*Please tick the appropriate boxes:*

- I agree to members of staff supervising the self-administration of medicines/providing treatment to my child as directed below.
- I agree to update information about the child's medical needs held by the school
- I will ensure that the medicine held by the school has not exceeded its expiry date

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian)

Name of medicine	Dose	Frequency/times	Completion date of course if known	Expiry date of medicine

**Special Instructions:**

**Allergies:**

**Other prescribed medicines  
Child takes at home:**

**PLEASE NOTE:**

**Medication is disposed of by the first aider when it reaches the expiry date.**