St John of Jerusalem
Church of England Primary School

Essential Medical Information

Confidential

ADMISSION DATE		UPN NUMBER	
YEAR		YEAR GROUP	
CHILD'S FULL NAME		DATE OF BIRTH / /	
PREFERRED NAME		BOY [ ] GIRL [ ]	
FULL ADDRESS			

FAMILY	Position in Family
Are there other siblings in the school? YES [ ] NO [ ]	1 2 3 4 5 6 7 8 9 (cross the no. of children and circle the child's position in the family)
Name of sibling(s): (1) (2) (3) (4) (5)	ASYLUM SEEKER YES [ ] NO [ ] REFUGEE YES [ ] NO [ ]

Does your child suffer from any of the following?			
Eczema	YES [ ] NO [ ]	Asthma	YES [ ] NO [ ]
Migraine	YES [ ] NO [ ]	Epilepsy	YES [ ] NO [ ]
Diabetes	YES [ ] NO [ ]	Sight Problems	YES [ ] NO [ ]
Allergies	YES [ ] NO [ ]	Hay Fever	YES [ ] NO [ ]

Any other problem/disability?	
If the answer was YES to any of the above	
What is the normal treatment?	
Any other information relevant to the problem:	

Does your child wear glasses in school?	YES [ ] NO [ ]	Is your child toilet trained (nursery admissions)?	YES [ ] NO [ ]

DOCTOR

Please give the name and address of your child's doctor

NAME		TELEPHONE	
ADDRESS			

Has the doctor put any restrictions on physical activities (e.g. swimming, PE)?	YES [ ] NO [ ]
If YES, give details:	
Is your child allergic to plasters?	YES [ ] NO [ ]
Are there any restrictions on any particular food?	YES [ ] NO [ ]
If YES, give details:	
Has your child been vaccinated against Tetanus?	YES [ ] NO [ ]
If YES, give date of vaccination:	