



Medical Update Form

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**General Practitioner's Details**

Name of family doctor: \_\_\_\_\_ Telephone number: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**Medical Information:**

***(Please provide any medication your child requires to a member of our admin. team who will check this alongside this form. Ensure all medication is clearly labelled and check it is in-date. Please also record if your child self-administers any medication you detail below)***

Does your child suffer from Asthma?

Yes / No (please circle as appropriate)

If yes, which medication is prescribed for him/her?

\_\_\_\_\_

\_\_\_\_\_

What are the directions for use:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any allergies?

Yes / No (please circle as appropriate)

If yes, please provide full details below (including any medication prescribed for him/her)

---

---

---

Does your child have any other medical conditions?

Yes / No (please circle as appropriate)

If yes, please provide full details below (including any medication prescribed for him/her)

---

---

---

Does your child have any dietary requirements, which relate directly to a medical condition?  
(not likes and dislikes)

Yes / No (please circle as appropriate)

If yes, please provide full details below (including any medication prescribed for him/her)

---

---

---

Is there any other information we may need to know about your child, whilst they are in our care? If so, please provide full details below:

---

---

---

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Print Name: \_\_\_\_\_